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ABSTRACT

With the nationwide implementation of managed care and the eroding financial base for children's services, social service agencies need new organizational systems to survive. This handbook provides an overview of one new system, Total Quality Management (TQM), as it relates to the child welfare field. The book's chapters are: (1) "Total Quality Management and Its Applications to Child Welfare Practice"; (2) "Customer Service"; (3) "Leadership: The Role of Management in a TQM Organization"; (4) "Team Work and the Role of Employees"; (5) "Continuous Quality Improvement and Measurement"; (6) "TQM Work Process Analysis"; (7) "How TQM is Accomplished"; and (8) "Steps in the TQM Process." Each of the chapters includes exercises and contains references. The handbook's three appendices include a sample strategic planning process, a list of ten unique characteristics of high performance teams, and a list of suggested readings. (JS)

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Quality-Centered/ Team-Focused Management

John Hodge-Williams, Joy F. Spratley-Wynn & Cheryl Mason Godsey

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John Hodge-Williams, Joy F. Spratley Wynn
& Cheryl Mason Godsey

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INTRODUCTION

This handbook is designed to be a resource for managers and employees in child welfare practice who want to focus on quality and team work, both in the way they offer services and in the way they organize and run their agencies. More and more public agencies are using Total Quality Management (TQM), because our work is changing rapidly and our organizations must adapt to remain relevant and effective in the years ahead. For example, listed below are some of the challenges that we have faced at the Woodbourne Center:

- Capitated rates mean doing more for less,
- Funders demanding data on specific outcomes/results,
- Greater competition created by fewer dollars,
- General public insisting on greater accountability, and
- For-profits entering the human service arena and publicly criticizing nonprofit agencies for lacking "good business sense."

In this handbook, we present a concise introduction to the overall concepts of TQM and how those concepts relate to the issues and needs of child welfare programs. The key TQM principles of customer service—team work and continuous improvement—serve as the context for the handbook. In Chapter 1, we present the Seven Practices of TQM, which agencies need to follow in implementing TQM, and illustrate these practices with a pyramid; that figure is repeated when practices are discussed. Each chapter also provides exercises for the reader to complete. These exercises are intended to clarify the concepts presented in the chapter and to help readers draw on their own experiences and work situations in order to apply TQM theory to practice.

Throughout the text we have inserted important concepts, or "Key Points," and ideas to think about, or "Consider this ..." These passages will help the reader focus on the major points related to TQM. In addition, we have also provided the reader with discussions on how TQM principles and practices can be applied to the operations of public agencies, using some specific examples from our work at the Woodbourne Center.

After completing this handbook, readers will understand how their agency will see the following benefits from implementing a TQM organizational philosophy and strategy:

- The agency will respond better to the changing needs of the children, families, and communities they serve. The agency will also work more efficiently with referral agencies and other partnerships because of its increased focus on customers and its commitment to quality service.

- The agency will empower case workers and other staff as they work in teams at the point of service to handle the increasing complexity of child care and treatment. The agency will also enable management to work strategically in allocating the agency's resources by obtaining data that identify what is working well and what needs improvement.

- The agency will reduce the cost of services, because all employees are committed to taking responsibility for effective and efficient work activities and processes. Employees will have high morale, because they are recognized and rewarded for taking on such responsibilities.

It is not a fast or easy journey to become a quality-centered/team-focused agency, but it may well be a vital journey. Not only must our agencies have the right mission and objectives for serving our children and doing our best, now we must also have effective philosophies, strategies, work processes, and methods to carry out those objectives in ways that the public respects and sees as quality work that models the virtues of what we say we are and what we say we do.

The TQM concepts and practices we describe in this handbook are the products of Woodbourne's own learning experience and those of the professional quality trainers we have used to become a better organization.

Scott Brumburgh edited this manuscript and expanded our specialized management training manual into a handbook for newcomers to TQM. The material he developed draws extensively on the training literature written and developed by Lynnette Yount, with whom he has worked on quality-centered/team-focused training over the past eight years. Special thanks also go to **Sheryle Parsons Yount** for her support and administrative assistance on the drafts of the handbook. We would also like to acknowledge **Dr. Julia B. Anderson** for her contribution to the original manuscript.

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1

Total Quality Management and Its Applications to Child Welfare Practice

This chapter explores what quality is and what we mean when we use the word. We offer a customer-centered definition of quality and examine the importance of meeting customer needs and requirements. The sections that follow provide the conceptual framework of the *Total Quality Management* (TQM) approach (including an historical perspective tracing the development of this philosophy), compare the main theorists of the quality philosophy, and discuss the implications of TQM for child welfare agencies.

What is Quality?

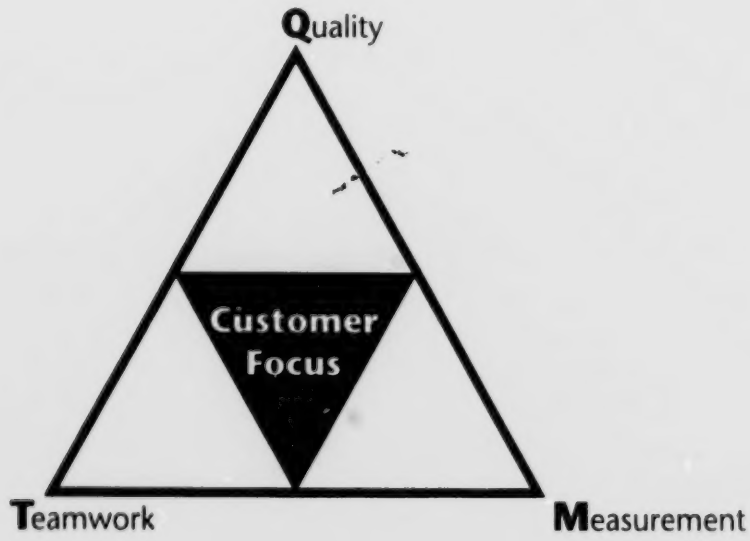
We usually think of quality as a predefined standard against which all products or services are measured. In the TQM philosophy, this is not the case—instead, the customer defines quality. In other words, what the customer wants and expects from your organization dictates the level of quality of the services and products that you provide. In TQM, then, quality is defined as "meeting the customer's needs and requirements the first and every time."

That definition is in stark contrast to the traditional one which stated that those who provide the services and products, especially an organization's management, determine whether the quality is good or not. This shift in emphasis from management to customer has gained attention and emphasis in countless organizations, making quality the workplace buzzword of the 1990s. In fact, some speak now of a quality

revolution or quality movement in America. Look at these examples of how quality is now emphasized in Ford Motor's slogan, "Quality is Job 1"; in Florida Power/Light's slogan, "When You Preach Quality, You'd Better Practice It"; and in Ernst & Whitney's slogan, "Quality in Everything We Do."

TQM is the intentional application of quality principles to an organization's services and products. The conceptual framework of TQM is represented in the letters T-Q-M (See Figure 1.1). It is useful to think of Quality "resting" on a balanced base of Teamwork and Measurement. Both aspects, the human and the technical, are needed for quality to succeed. If you can remember these three letters, plus customers, you have the essence of Total Quality Management: a strategic, integrated management system for achieving customer satisfaction, which involves all managers and employees and uses quantitative methods to continuously improve an organization's processes.

Figure 1.1
TQM Conceptual Framework



Depending upon whom you read in the literature on quality, the definition of TQM will vary somewhat. The definition we prefer, however, is one that covers the key ideas of the major American theorists.

Definitions of TQM will also vary among organizations. The health care field often refers to TQM as Continuous Quality Improvement. The U.S. Navy calls it Total Quality Leadership. In the private sector, the definition typically includes responsibility for financial management and a good return for investors.

When people are asked to identify their criteria for the quality of a service or product, they invariably make the point that, if it matched their expectations and met their criteria, then it was of quality. There are three key points the reader should remember about Quality:

1. **The traditional notion that quality is a high, difficult, and expensive standard to attain is not necessarily true.** Mercedes-Benz is not the only quality car; in fact, some of the highest quality cars are now in the lower end of the price range. Quality is not necessarily expensive.

2. **Quality is often a matter of perception, not fact; the definition of quality can vary depending on your expectations.** When you go to a fast-food restaurant for a hamburger, you are probably pleased with the quality of the food, because what you get is what you expected. That is one of the main strengths of fast-food restaurant chains—you can go practically anywhere in the country (now even the world) and get a hamburger that tastes just like the one in your own town. If you went to a fine restaurant, however, and ordered a hamburger, expecting it to be top-quality meat cooked to order, and received a hamburger that tastes like a fast-food product, you would probably be displeased. Different standards of quality can exist at many different levels.

3. **As customers, people will vary in their expectations of services and products** (e.g., functionality, durability, ease of use, maintenance, cost effectiveness, etc.). Even with as basic a product as a #2 pencil, customer needs may differ greatly. A student may want a thick one that is easy for young hands to hold and a large, resilient eraser to handle the rigors of homework and test taking. An office worker, however, may prefer a slender, rounded, and lighter pencil that is easy to use throughout a long day at the desk. Today, customers can be expected to have different needs and expectations in functionality, durability, ease of use, maintenance, and cost effectiveness.

Historical Perspective of TQM

In the 1980s, many American companies began to seriously explore and adopt Total Quality Management principles. Indeed, TQM practices were responsible for the turnaround of some major businesses that were in trouble during the 1970s (e.g., Ford Motor Company and Xerox). The first Federal agencies to practice TQM were the U.S. Department of Defense and the Internal Revenue Service. Child welfare agencies have only recently begun to apply quality principles in earnest.

The story of TQM in America, though, is told in how Japan and Germany, whose economies were shattered, major industries destroyed, and populations decimated at the end of World War II, made an incredible economic comeback in the 1970s. Ironically, it was American ingenuity that contributed to the successes of these countries.

World War II and Its Aftermath: Japan's Rebuilding Management Approach

During World War II, management and production theories were pressed extensively to increase U.S. wartime production. Management and small group processes were studied, for example, to maximize use of human resources in the war effort.

After the war, Japan imported American technology—hard technology for the rebuilding of the country's industries and soft technology for the rebuilding of its human systems. (Incidentally, when we turned to Japan in the 1970s to figure out how the country had become so technologically advanced, the Japanese managers said, "Why are you asking us? We got these ideas from you!")

The hard technologies involved streamlined technical work processes and increased use of automation. They also involved creating new information management systems based on the use of computers. The soft side focused on such management processes as performance appraisals and recognition systems, leadership and staff development programs, training in interpersonal skills, feedback and continuous improvement methods, and approaches for employees to change and adapt to new technologies in their workplace.

Germany's Rebuilding Business Management Approach

The German experience was somewhat different from that of Japan. Both American and British advisors assisted Germany in its recovery and established an extensive legislated system of Work Councils that

reviewed corporate activity. These groups acted as advocates for employees and pushed for new group work methods that would improve economic performance and working conditions.

The concept *Lernstatt* (learning shop) became the primary force in German management. This approach emphasized individual training and education to improve skills and performance. (This is consistent with American research on both leadership and personal/organizational development.[1]) In the last decade, German businesses have introduced Quality Circle programs, and more than half of the major German companies now use quality improvement teams, integrating them with the concept of the learning shop.

America's Postwar Business Management Approach

Postwar America experienced a major boom. After years of austerity from the depression and the war, the population could not be satiated in its desire for goods and services. The prosperous 1950s produced quantity, and the popular belief was, "If we make the most inexpensive products in the world, people will buy them." (Japan's conclusion from the same basic technologies was, "If we make the *best* products in the world, people will buy them.") The advent of computers and robots in the 1960s and 1970s masked the problems that were surfacing in American business. Bottom line profits and planning for the short term became the norm.

During the 1970s, however, American business began to feel the pain of decades of not attending to the real concerns: the gas crisis and subsequent decline of the American automobile industry, the failure of the steel industry, the decline of the "American work ethic," the disillusionment of workers, and the deepening adversarial relationship between management and labor. It became obvious that Japan (and some other countries) knew something we did not.

American businesses tried many different programs in the 1970s in an attempt to remedy the declining situation. Most notable of these was Quality Circles, a participative management program. Some of these attempts were quite successful; others failed due largely to the lack of integration and support from management. The prevalent operational model was factory manufacturing with a propensity for chains of command centered around power, control, rules, and regulations. Leaders accustomed to this style of managing found alternative approaches to running their organizations too radical.

Integration of Technical and Human Management Components

Even as the Japanese began to evolve a system of Total Quality Management, they too had to overcome problems. Workers were suspicious of being "measured," people did not agree on the usefulness of the approach, etc. The Japanese had established a voluntary adherence program to nationally established production standards and were using Statistical Process Controls, a system developed by American economist W. Edwards Deming, who advocated such measures as abolishing performance appraisals, empowering the workers, and eliminating inspections. He also insisted that the support of top management was essential. Joseph M. Juran then became involved with training Japanese companies in quality management. He contributed ideas about how to make the concepts work and focused especially on the importance of paying attention to human issues.

Quality As a World Standard

By the early 1970s, everyone in America was aware of how phenomenal Japanese products had become. As the quality movement has spread across the Pacific back to us and around the world, it has established a global expectation of quality. When we go to a store to purchase a new television, radio, computer, or toaster, we expect high quality (durability, performance, etc.) in several price ranges. We expect to be able to compare local or U.S.-made goods with those of other countries for style and options, as well as price. We even expect such seasonal fruits and vegetables as raspberries and asparagus to be available year-round. Twenty years ago, the expectation was that only American-made goods would be available in quality and selection at reasonable prices, and that some items would be available only at certain times in certain places. Today's market is a global market, whether you live in New York City or Dodge City, Kansas.

Comparison of TQM Theorists

Philip Crosby has made a major contribution to TQM and has become one of America's "gurus" of TQM, along with Juran and Deming. Other early contributors from Japan include Ishikawa and Taguchi.[2] Many others have joined the ranks of respected authors on quality and customer service. The contributions of Deming, Juran, and Crosby to TQM in this country have created for them an international reputation. Together they have provided the framework and context for applying the

principles, concepts, and tools of quality that is known as TQM. Following are brief descriptions of these three theorists and examples of their work.

W. Edwards Deming (1900–1993) was a statistician, physicist, and educator who is widely credited with leading the Japanese quality revolution. His message can be summarized as "the basic cause of sickness in American industry is failure of top management to manage; responsibility for change rests with management." Following are his "14 Points of Management Obligations."

1. Create constancy of purpose for improvement of product and service.
2. Adopt the new philosophy.
3. Cease dependence on mass inspection.
4. End the process of awarding business on the price tag alone.
5. Improve constantly and forever the system of production and service.
6. Institute training.
7. Institute leadership.
8. Drive out fear.
9. Break down barriers between staff areas.
10. Eliminate slogans, exhortations, and targets for the work force.
11. Eliminate numerical quotas.
12. Remove barriers to pride of workmanship.
13. Institute a vigorous program of education and retraining.
14. Take action to accomplish the transformation.

Reprinted with permission of Putnam Publishing Group from M. Walton, *The Deming Management Method* (New York: 1986), pp. 34–36.

Joseph M. Juran (1904–) was born in Romania and came to the United States in 1912. An electrical engineer, lecturer, government administrator, and contemporary of Deming's at Western Electric, Juran defines quality as "the users of a product or service being able to count on it to do what they need when they need it." Following are Juran's key quality planning, control, and improvement steps:

1. Identify the customers.
2. Determine customer needs.

3. Develop product features that respond to customer needs.
4. Establish quality goals.
5. Develop processes that produce the needed product features.
6. Prove the process can meet the quality goals.
7. Measure actual performance.
8. Prove the need for improvement.
9. Organize and diagnose to find problem causes.
10. Provide remedies that are effective.
11. Provide for controls.

From J. M. Juran, *The Quality Trilogy: A Universal Approach to Managing for Quality*, with permission of author. (Paper presented at the ASQC 40th Annual Quality Congress, in Anaheim, California, 1986.)

Philip B. Crosby (1926–) began his career as a junior technician with Crosley Corporation and subsequently held positions with the Bendix Corporation and ITT, where he was Vice President for Quality before he founded his own business and quality college. His perspective asserts, "If quality were improved, total costs would ultimately fall and actually allow profitability to increase—concluding that quality is 'free.'" Following are Crosby's "14 Steps to Quality Improvement."

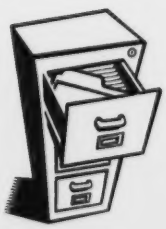
1. Make it clear that management is committed to quality.
2. Form quality improvement teams with representatives from each department.
3. Determine where current and potential quality problems lie.
4. Evaluate the quality awareness and personal concern of all employees.
5. Raise the quality awareness and personal concern of all employees.
6. Take actions to correct problems identified through previous steps.
7. Establish a committee for the zero defects programs.
8. Train supervisors to actively carry out their part of the quality improvement program.
9. Hold a "zero defects day" to let all employees realize that there has been a change.
10. Encourage individuals to establish improvement goals for themselves and their groups.

11. Encourage employees to communicate to management the obstacles they face in attaining their improvement goals.
12. Recognize and appreciate those who participate.
13. Establish quality councils to communicate on a regular basis.
14. Do it all over again to emphasize that the quality improvement never ends.

Reprinted with permission of McGraw-Hill Book Company from P.B. Crosby, *Quality Without Tears* (New York: 1985), p. 99.

While these theorists disagree on the details and some aspects of how to implement TQM, they are in agreement in many key areas:

- Quality costs less because there is less waste.
- *Preventing* quality problems is better than detecting and correcting them.
- Statistical data should be used to measure quality.
- Managers must take a leadership role in improving quality.
- Managers and employees need training in quality improvement.
- Organizations need to develop quality management systems.



A **key point** on TQM theory is that *there is no one right way to become a quality organization.* The generic TQM model presented in this handbook encompasses the best of the theorists; as a result, readers have a reliable framework for customizing an approach that meets the specific needs of their agency and customers.

TQM in Child Welfare Practice

Why are child welfare agencies adopting the TQM philosophy? Fewer financial resources, changing work force, demands for service, demands for quality, and openness to new ideas are the major common reasons that most organizations implement TQM.[3]

Fewer Financial Resources

The American public has become more discriminating in wanting to see the results of their contributions to public service organizations. To ensure the public's ongoing trust in organizations regarding the use of

money, public agencies will need to demonstrate good management. Child welfare centers in the past had little competition for their services and few questions about their approach to out-of-home care. That is no longer the case: now there are more not-for-profit centers in the same geographical area with different approaches. Agencies need to show quality results to the people who support them. Consider the following key points:

- Funders will require agencies to contract for functions,
- Public agencies are competing with private agencies for the same dollars, and
- With private vending of services, more liability gets spread among all parties.

Changing Work Force

More and more jobs in the near future will be skilled technical jobs rather than skilled labor jobs. The skills and competencies that child care workers need, for instance, have changed from the less demanding caregiving service role to the more demanding role of providing a continuum of care and treatment services. Organizations are also trying to make a shift that will respond to cultural and other impacts of diverse groups included in the work force: women, African Americans, Latinos, and Asians. The TQM emphasis on individual contribution and teamwork offers some solutions.

Today, even the customer is changing. Today's customers grew up in a different world, with different expectations than their parents. To respond more effectively to children's needs, agencies need to consider the following key points:

- Focus on cultural diversity and the changing demographics of workers as well as customers,
- Address the cross-training needs and downsizing that results from fewer resources,
- Value individual contributions, and
- Value the individual need to excel.

Demands for Service

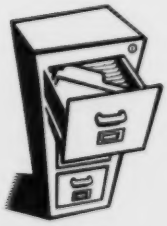
The American public—the consumer—is demanding quality service. People will no longer tolerate poor, inconsistent, or inconsiderate service.

The American consumer brings the same demand to the public service sector, and the need for excellent service is pressing. The public expectations of child welfare practice has changed dramatically in recent years. Agencies that began as orphanages are no longer providing care for orphans only, for example. Today's customers demand versatility in dealing with the complexities of drug and sexual abuse, abandonment, and in anticipating new problems and priorities each year. Other key points to consider include the following:

- The major expansion of the concept of individualized services (wraparound, flexible dollars);
- The emphasis on community-based care;
- The rise in the incidence of emotional problems, especially in urban areas;
- The major shift from social problems to public health and safety;
- The shift from treating child and family to treating neighborhoods and organizations; and
- Consistently high expectations, despite a decrease in available monies.

Demands for Quality

Again, Americans want high quality. This demand applies across the board from home purchases to public services and products. For child welfare agencies, the old "Do whatever it takes to fix the problem completely" philosophy must, in response, give way to the philosophy: "Do it right, effectively, and efficiently." Agencies can no longer determine the quality of care based on the input of case workers and other treatment providers alone. Agencies now have to be able to back up their approaches and conclusions with data from decision makers and evaluators outside the field.



Key points to consider on quality include the following:

- A commitment to high quality,
- An appreciation of high ethical standards,
- The realization, on the part of the funders, that quality may not be diminished with less funding, and

- The understanding that private agencies are becoming more responsive to managed care initiatives.

Openness to New Ideas

Organizations must develop and sustain the ability to innovate and to produce quality goods and services to meet ever-changing customer requirements. Those who cannot will fall by the wayside, like the famous Edsel. A few years ago, WordPerfect had the market on the word processing industry. WordPerfect apparently thought that, because virtually everyone used their program, customers would continue to use it indefinitely. Because the company didn't adapt to changing software technology, management subsequently lost their lead market share. In health care, the new idea that must be addressed successfully is the shift from the concept of medical professionals being seen as "gods," to a view that professionals are resources for the patient to use.

Openness to new ideas starts with listening and paying attention to people inside the organization, especially those on the front lines of customer services. Organizations will need to value creativity and innovation, listen and respond to ideas from within the organization, and adapt to changing customer needs and expectations, or become irrelevant.

Summary

For any child welfare agency that intends to survive into the 21st century, the answer to the question, "What is quality?" lies partly in having a customer-centered focus about how you serve and what you produce.

The guiding principles for agencies implementing TQM, based on the agreement of leading theorists, are ***Quality*** (the organization focuses on delivering customer satisfaction); ***Teamwork*** (quality becomes the responsibility of every manager and employee); and ***Measurement*** (of all services and products) that is continuous and largely derived from data, not hunches.

Organizations that want to successfully implement a program founded on these principles will need to follow the "Seven Practices of TQM," and it is management's responsibility to ensure the effective implementation of these practices. This handbook explains these practices (illustrated in Figure 1.2) and uses the TQM model developed by the Federal Quality Institute.[4] Chapter 2 discusses the importance of the customer focus, which resides at the center of our TQM model.

Figure 1.2
The Seven Practices of TQM

Adapted from the Federal Quality Institute model.

Exercise 1.1

To introduce the concept of *Quality*, let's begin simply with something we all use—an ordinary #2 pencil. Locate one for yourself and then follow the instructions below. (This exercise has the most impact if another person or small group does the exercise as well, so you can compare remarks.)

1. Take a minute and determine the following: if you were to use this pencil at work, would it be a quality pencil? Please write your response, and state why it is or is not a quality pencil.

2. Rate the quality of your pencil on a scale of 1 to 10 with 1 being extremely poor quality and 10 representing extremely high quality.

3. Next, list your personal requirements for a quality pencil. That is, what qualities does this pencil need to have to be a quality pencil for work?

If we reviewed your responses, we would likely find that your *expectations* contributed to whether you judged the pencil to be of high quality or not.

Exercise 1.2

Read the points of all three "quality gurus," then identify similarities and main differences between the theorists.

Here is how we briefly contrast the three authors:

Deming: ***The master of statistical control***

Continually ask the questions: "What are we doing?" and "Why?"

Exhortations and prescriptions.

Juran: ***The master of how to do it***

Implement and achieve quality.

How-to's.

Crosby: ***The master of getting people on board***

Create a vision and inspire commitment.

Affirmations.

Exercise 1.3

The following questions will encourage you to reflect on the viability of TQM in your agency.

1. What is the political climate for the acceptance and implementation of TQM in child welfare practice?

2. What are the barriers to TQM implementation?

3. What are the driving factors for TQM implementation?

4. What is the potential for TQM in your agency?

Draw your conclusions here on whether TQM is a fact or fad.

Notes

1. Examples include P. M. Senge, *The fifth discipline* (New York: Doubleday, 1990); and W. Bennis & B. Nanus, *Leaders: The strategy for taking charge* (New York: Harper & Row Publishers, 1985).

2. K. Ishikawa, *Guide to quality control* (New York: UNIPUB, 1985); and L. A. Ealey, *Taguschi methods and U.S. industry* (Dearborn, MI: ASI Press, 1988).

3. J. Hodge-Williams, J. B. Anderson, and J. F. Spratley, *Getting started with quality centered/team focused management* (unpublished manuscript), pp. 5-6.

4. Model developed by the Federal Quality Institute, Office of Personnel Management staff for distribution throughout the Federal system, 1990-1991. This organization no longer exists and materials cited throughout this document are unavailable.

2

Customer Service

The primary goal of TQM is to provide excellent customer service. Once customers are identified and their requirements clarified, then it is the job of the organization to provide excellent service and quality products, delivered on time, of good value, and from courteous and helpful employees.

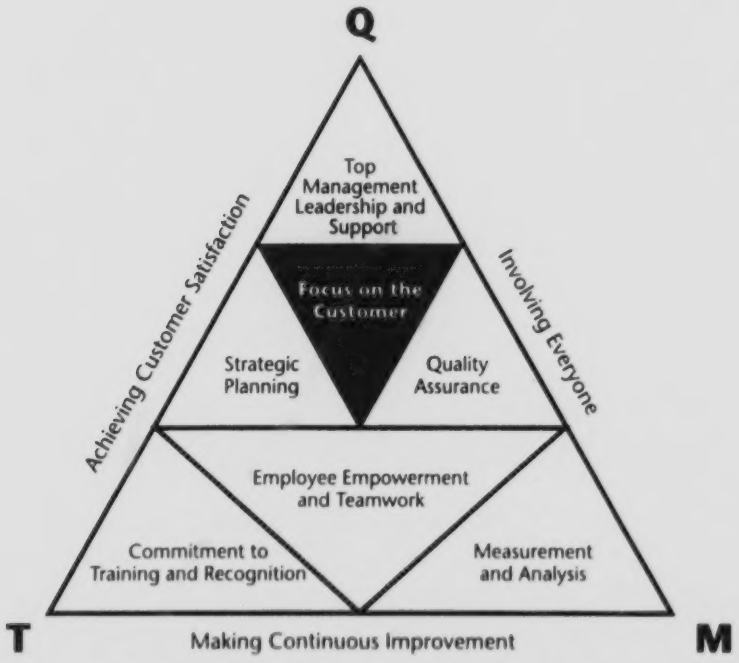
This chapter defines two kinds of customers: those within the organization and those outside it. The following sections focus on how organizations can distinguish customers from the stakeholders and suppliers who form the other critical components of the organization's quality partnership, explore customer requirements, and discuss who in the organization is responsible for making everyone aware of customer needs. The final section reviews how agencies can use the TQM approach to accurately understand what customers want and to integrate those requirements into an organization's operation.

Who Are Our Customers?

Because the success of organizations is significantly affected by how customers determine the quality of their products and services, the starting place for understanding TQM is the customer (see Figure 2.1). We must identify exactly *who* the customers are. The organization needs to clarify customer requirements and direct its effort toward fulfilling those requirements and exceeding customer expectations whenever possible. This sounds like the obvious goal of any organization, yet we know that organizations can become sidetracked by other issues and neglect their customers (defined as anyone who receives products or services from someone else).

Figure 2.1
TQM Practice #1: Focus on the Customer

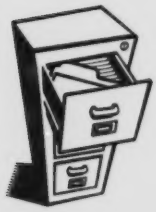
Adapted from the Federal Quality Institute model.



American organizations have typically operated under philosophies different from the customer-focused one. The traditional approach in business, for example, was to think of a new idea, sink a lot of money into research and development to design and develop the item, and turn the product over to the marketing department to create a market niche and then to advertisers to convince the public they need that product. This approach bypassed the most important and obvious question of all: "Does anybody really need or want our product?" The Japanese, on the other hand, have become masters of the customer-oriented approach and succeeded in selling their products to the American consumer, most notably in the automobile and home entertainment industries.

Two Kinds of Customers

TQM further defines customers in two ways—those within the organization and those external to it.



Following are **key points** to remember about who the customer is:

- Anyone who receives our products or services inside the organization is our *internal customer.*
- Anyone who receives our products or services outside the organization is an *external customer.*

Who Are Our Internal Customers?

The concept of *Internal Customer* is a new one—another important contribution from the TQM philosophy. Internal customer service is critical to the quality organization. It means that we treat our coworkers with the same respect and professional behavior as we would treat our clients. This one concept alone, if practiced, can revolutionize the way we do business. It is also an idea that can be implemented without top management approval. Each participant can work in a manner that breaks down a barrier that may exist between coworkers or between an office and another division. The term "hidden customer"[1] illustrates the fact that we often fail to recognize our organizational colleagues as vital customers. Internal customers may include the following:

- Peers;
- Subordinates;
- Supervisors and managers; and
- Other offices, departments, programs, and divisions within the organization.

Who Are Our External Customers?

Organizations have various ways of identifying their customers. In private industry, this often includes market research, demographic studies, population segmentation, etc. In government, customer identification is often done in conjunction with clarifying an agency's decision-making processes—if it does not benefit our customers, why are we doing it?

A child welfare agency's external customers typically include the following:

- Children and families in need;
- Federal, state, county, and local public agencies;
- Private social agencies at the regional level;

- Hospitals and universities; and
- The community—neighborhoods, service organizations, and businesses.

External customers for child welfare agencies are our traditional clients, beginning with the children and families who come for treatment and extending to the neighborhoods where treatment centers are located and that are directly involved and served under the child/family treatment approach. (This includes the businesses that hopefully will employ some of the children in the future.) Agencies receive most of their child referrals (and funding) from, and thus also serve, an array of governmental and private service agencies at the community, county, state, and national levels. The laws and regulations of all these layers of government must be satisfied for the agency to receive and use grant monies.

Once an agency has received funding, it must prioritize the needs of different customer groups—children, families, and external agencies. This is often a big issue for centers, as each customer may have different, even competing demands. For example, an agency that has intense on-site treatment may need to consider the children and families it treats as "Primary Customers" and call them internal customers.

Consider this ...

Whose customer are you? Think about your own job for a moment. Who gives you what you need to do your job? Who do you depend on to provide you with the necessary goods and services to produce your work? You are the customer of these people.

Who are your customers? On the other side, you've been on vacation for a week, and you are picking up your telephone messages. Who are they from? They are probably from your internal customers—the people who need information, help, products, or services from you to do their jobs.

The Other Key Players: Stakeholders and Suppliers

In TQM, the quality partners are the customers, stakeholders, and suppliers. Clarifying who our customers are also requires clarifying who our customers *are not*. Establishing the distinctions between an organization's customers, stakeholders, and suppliers is critical. An

understanding of the relationships among the partners contributes to the organization's work process improvement to increase quality.

Stakeholders are individuals and organizations that have an interest, or stake, in your organization and the decision-making process. Sometimes they can influence your decision making and sometimes they themselves are affected by your organization. In many organizations, due to management style, or because of political pressures and realities, employees often serve their stakeholders instead of their customers. Stakeholders may include boards of directors, donors, the U.S. Congress, government oversight committees and regulatory agencies, and local political officials.

Just as organizations have internal and external customers, there are also internal and external **suppliers**. *Internal suppliers* provide material or services from within the organization for the implementation of work operations and may include physicians, psychiatrists, providers of medical and other treatment services, providers of forms and other materials, and building and grounds maintenance. *External suppliers* provide materials or services to your organization from outside and may include companies that provide child referral data and discharge information, computer hardware and software, medical services, and other specialized services.

An organization's service or product can only be as good as its suppliers' services or products. Many organizations are now working closely with their suppliers to improve quality. Some organizations invite members of supplier organizations to join quality improvement teams and participate directly in the organization's quality improvement process. In fact, several supply organizations report that they were driven to implement TQM in their own shops because of demand from their customers. This has been particularly true in manufacturing industries, where TQM can cause a chain reaction in other related industries. Some companies only use suppliers that participate in TQM themselves.

Determining Customer Requirements

In the traditional business approach, management was responsible for setting customer requirements and telling employees what and how to serve their customers. In many organizations this pattern continues—organizations plan their work with little or no customer input. Many employees still believe it is management's job to determine customer requirements and integrate these needs into how work is accomplished. It is important to answer the questions: "How do we determine what the customer requires or expects?" and "Whose responsibility is it in the

organization to make sure everyone is clear about customer requirements?"

In TQM, it is every manager and employee's job to learn what their customers require and to help the organization provide products and services which meet those needs. Only in this way can the organization be assured that quality is built into every product component and each service opportunity that reaches the customer. Typical internal and external customer requirements are listed below.

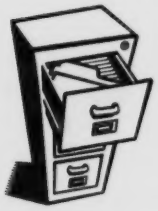
Internal	*External*
Timeliness	Functionality
Accuracy	Usability
Clarity	Cost/Performance
Thoroughness	Reliability
Physical Characteristics	Availability
Completeness	Maintainability

Managing Customer Requirements

Everyone wants it cheaper, faster, and better. While over time this may be possible to achieve (e.g., the computer industry), it is usually not possible immediately. Customer requirements need to be negotiated. Thus organizations must conduct a balancing act when they choose among the requirements listed above. For example, if an organization decides to raise the standards of a particular product or service to meet the customer's requirements, it needs time to develop a better product, money to purchase better supplies, or time to train people in the new service process. If the product or service is sufficient, but the customer wants it faster, the organization may need to spend money by hiring extra employees or providing overtime. If the product or service is too expensive for the customer, the organization may need to renegotiate standards to decrease costs. And almost any shift in production or service requires time to analyze the process and effectively improve it.

Consider this ...

> The three variables to manage in addressing customer requirements are cost, time, and standards. A change in any one of these automatically creates a change in the other two.



There are two **key points** to consider in managing customer requirements:

1. **It is the responsibility of management to establish customer requirements.** Managers need to know what customers *want* and *why.* This applies to both internal and external customers. Although employees participate in this process of clarification, management is responsible for making sure the organization knows what the customer wants. This requires a cross-functional view—knowing how processes and products work across divisional boundaries. Management needs to link the processes together to make sure the final product and point of service meet customer expectations.
2. **Management needs to make the choice about how best to address customer requirements.** One way to accomplish this is to improve services or products so they meet the customer requirements. One of the most effective methods for addressing customer requirements in child care agencies is to sponsor focus groups with clients, parents, and funding agencies. Your customers will tell you what they need but are not receiving from the agency.

Providing Quality Customer Service

The TQM approach begins with the customer—the "outside-in" approach—then finds out what is needed and what is wanted (as opposed to the traditional, "inside-out" approach). Design begins from this point. The organization generates services and products in ways that satisfy customer requirements, and exceeding these requirements is what retains customers. It is crucial for customers and suppliers to develop effective, mutually beneficial, ongoing relationships.

The idea of asking our customers what they need from our services or products to receive quality results sounds simple. In fact, however, it is a behavior that takes time to acquire effectively. In some TQM training programs participants are asked to perform a brief and easy task for another participant: each becomes a "customer" and a "supplier" to the other. When participants discuss the result of the exercise, there are usually as many "suppliers" who did not meet the requirements of their

"customers" as those who did. The "suppliers" are then asked, "How did you get your customer to specify his/her requirements? Did you write all of them down? Did you, as supplier, clarify the request verbally? Did you ask questions to make sure you understood the request?" Because many "suppliers" will assume they know how to "do their job" (e.g., get a soft drink), they do not check carefully enough with their "customer" to make sure they will provide a quality service or product the first time.

A critical customer service issue facing child welfare agencies today is how much input children ought to have in their care and treatment. This issue grows out of the shift in treatment theory and practice, coupled with the changing public attitude toward children's rights. The current trend for agencies is to encourage children to have greater involvement in identifying their own issues and needs and for the treatment teams not to dictate the nature and extent of the care to children.

Consider this ...

Old paradigm: Give customers what you think they need.

New paradigm: Focus on quality as defined by the customer.

Summary

Once an organization has committed itself to TQM, the next step management must take is to have the organization clearly identify its customers. This sounds obvious, but it is actually a common malady in organizations—confusion around who actually uses the organization's products or services.

In TQM, management typically uses the strategic planning process to agree on customers (discussed more fully in Chapter 3). The organization should be clear about who its external customers, suppliers, and stakeholders are. At various levels throughout the organization, however, identification and clarification of customers, especially internal customers, probably needs to be a continuing endeavor. Change happens quickly in these times, and customers and suppliers change just as rapidly.

The focus on customers is the primary difference between the TQM approach and the traditional approach. TQM organizations design services and products from the "outside-in," while the traditional way is from the "inside-out." In traditional systems, ideas are only created from within for better or new services or products. Extraordinary time, money,

and effort is typically undertaken with little or no input from the organization's actual customers.

Providing customers with more than they expect is a goal many organizations are attempting and achieving. By exceeding their requirements you can "dazzle" them. Tom Peters calls it "delighting" the customer;[2] Deming refers to it as "customer obsession."[3]

Exercise 2.1

1. How would your agency define an external customer?

2. List as many of your agency's customer types as you can.

3. Identify who your agency's most significant customers are, and why they are so important.

4. How would you say your agency treats internal customers?

Exercise 2.2

1. List your organization's stakeholders.

2. Is the issue of serving stakeholders rather than customers a concern in child welfare practice? If so, offer an example that affects your agency.

Exercise 2.3

1. Make a short list of the internal or external suppliers who provide you with products or services that enable you to carry out your work.

2. Name several individuals or units for whom you are the supplier—in other words, your direct customers.

Exercise 2.4
Typical Customer Requirements

Internal	*External*
Timeliness	Functionality
Accuracy	Usability
Clarity	Cost/Performance
Thoroughness	Reliability
Physical Characteristics	Availability
Completeness	Maintainability

Which of the above requirements do your customers most often ask of you? Why?

Exercise 2.5

1. Why would child welfare employees want to provide good customer service? What is in it for them?

2. How crucial is meeting customer requirements or expectations to the survival of your agency?

3. Provide three examples of how you could serve your customers better. **Note:** This is an actual technique used by organizations that practice TQM. They usually ask their customers to identify 10 ways they could be better served. This is a concrete way in which participants can practice TQM in their own venues, without direction from management. Anyone can improve their internal customer service by simply applying these ideas.

4. How would you go about implementing the concept of *customer service* within your own agency?

Notes

1. Salenger Films. *The hidden customer: A film about internal customer service* (Santa Monica, CA: Author, 1985).
2. T. J. Peters. *Thriving on chaos: Handbook for a management revolution* (New York: Harper & Row, Publishers, 1988).
3. W. Edwards Deming. *Out of the crisis* (Cambridge, MA: MIT Center for Advanced Engineering Study, 1986).

3

Leadership: The Role of Management in a TQM Organization

TQM requires a substantial commitment from individuals and the organization to be effective, and questions of quality, accountability, and responsibility affect each person in the organization. This chapter discusses the roles that CEOs and managers must fulfill for TQM to be successful and introduces the use of strategic planning as a key TQM practice.

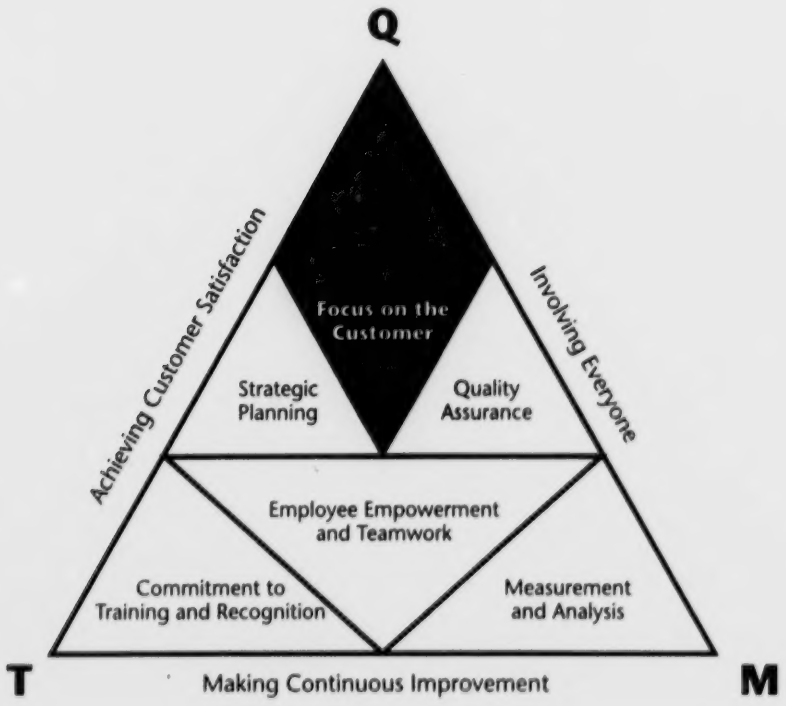
Identifying Who Is Responsible for Quality

The traditional view in management has held that responsibility for quality rests with designated individuals who conduct a complex system of checks, reviews, inspections, rejections, and reworking of defects. This approach, however, results in significant amounts of wasted time, materials, and effort. And if a subquality service or product leaves the organization and goes to the customer, more time and money is wasted in dealing with customer dissatisfaction, complaints, and returned products and correction or duplication of services.

The TQM view holds that quality begins with each employee of the organization. Each person is responsible for making sure that all work that leaves his or her hands is correct and meets requirements. Organizations can no longer afford to have some employees find all the mistakes or to allow anyone to perform poor quality work that bogs down the system. For this level of quality work to occur at all times, management must first make a strong commitment to quality (see Figure 3.1).

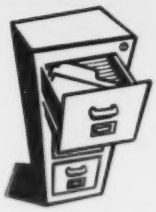
Figure 3.1
TQM Practice #2: Management Leadership and Support

Adapted from the Federal Quality Institute model.



Before TQM can succeed in an organization throughout the system, management must *decide* to create a high-quality organization and *choose* TQM as the pervasive management philosophy to support that decision. The experts agree that this is critical to the ultimate success of Total Quality Management.

This decision is not a small undertaking. It means transforming an organizational model that has existed for decades to a new service-oriented model for the 21st century. It will mean massive change in most organizations; up-front investments of time, money, and effort; successes and mistakes; the disruption that occurs with major change; and many years before the organization is fully "converted." Yet the results speak for themselves.



A **key point** to remember about management's commitment to quality is that the first step in creating a total quality organization is making the decision, usually at the highest level in the organization, to adopt TQM.

Senior management, and subsequently middle management, must ask the following questions and then answer them with a resounding "yes" if TQM is to be successful:

- Are you willing to change your organization?
- Will you create the environment for change?
- Will you train others and commit resources for that purpose?
- Will you demonstrate commitment by your actions?
- Will you positively reinforce progress?

These questions help to test the level of commitment to the TQM process. Each person in a leadership role, and the organization as a whole, needs to consider these items carefully. Some of the ways in which improvement programs fail are deficiencies related to these questions:

- Saying we want quality but failing to provide the resources to create it.
- Saying we want to empower our employees but failing to provide training.
- Saying we want to identify problems but punishing an employee for bringing one to our attention.

Commitment means behaviors consistent with TQM goals. Programs considering a substantial shift in managerial roles and responsibilities often failed in the past, because middle managers felt neglected, left out of decision making, or sabotaged. Organizations must take the concerns of managers in the implementation process seriously and handle those concerns creatively. Some organizations that are implementing TQM train their managers in the basics of TQM and then require managers, in turn, to train their employees. Sometimes managers become team leaders, and often they work on quality improvement teams at their level in the organization.

The Leadership Role of the CEO

It is difficult enough for the senior management of an agency to embark upon TQM. How does the chief executive officer prepare to be the overall leader and inspiration for a long-term, major organizational changeover?[1] The answer lies in part with personal growth and development and in part with mastering the change in the leadership role. The experts agree that such preparation for the top leadership role helps drive out fear, empowers staff, and provides the supportive environment necessary for TQM to thrive in the organization. (In the child care industry, the role of the chief executive officer is usually taken by the chief *educational* officer.)

Managers and employees are more likely to follow agency leaders who model the desired change in behavior, attitude, and acquisition of knowledge. Examples of such changes include taking the initiative to keep an open dialogue on the meaning and implications of TQM concepts as they are applied in the agency and helping guide and navigate the organization through the adoption of TQM initiatives. The role of modeling behavior and attitude changes differs dramatically from the role of imposing changes and applying punitive measures for mistakes, confusion, or disagreement.

By deciding to grow and change personally, the CEO can better respond to the challenge of leading change and promote greater trust and commitment by managers and employees in the organization and its operations. Today, CEOs in business and service organizations today *lead* people and *manage* resources. Their leadership comes from their ability to influence others, not to exert control over others.

Management's Role and Functions

In many ways, the TQM management role is similar to the traditional role. The specifics, however, are different, and the *ways in which management functions are carried out* must also be different. The list below illustrates how different company policies require different means of implementation:

Policy	*Implementation*	*Oversight*
Vision	Scope	Monitor
Strategic Plan	Resources	Adjust
Goals/Objectives	Customer Requirements	Evaluate
Priorities	Suppliers	Recognition
Improvement Plans	Training	Improvement Projects
Measurement Systems	Marketing Communication	

Management must give up the controlling, policing, and punishing function of the past and not fall into the pit of "undermanaging." The new role could be characterized as active sponsorship. In this role, managers are still responsible for the following:

- Providing direction for the organization (policy);
- Making sure that things get done, especially new TQM efforts (implementation); and
- Providing support and help in evaluation of quality improvement initiatives (oversight).

Once the agency has made a commitment to practice TQM, everyone must thoroughly understand the role of management. Managers must also provide the resources employees need to do a good job to create quality and the organizational structure that will support the implementation of TQM, especially as that structure relates to using employee solutions to problems and improvements to work processes. Figure 3.2 illustrates the manager's role in TQM.

Consider this...

Old paradigm: Manager seen as director, controller, police.

TQM paradigm: Manager seen as leader, coach, active sponsor.

Strategic Planning

Strategic planning is an important example of how management will function differently in TQM. Strategic planning is an intensive process, usually performed at the highest level in the organization, that clarifies basic assumptions about the organization's business and how it is performed and establishes direction for the future (see Figure 3.3).

In the TQM context, the strategic plan generally includes a mission, vision and values statements, clarification of customers, and establishment of TQM goals. Organizations should review the definition of three of these terms, since many sometimes combine their mission and vision statements, blurring distinctions and creating confusion.

Figure 3.2
The Total Quality Management Journey: The Manager's Role

From L. Yount, *Total Quality Management: An Overview* (Arlington, VA: Lynnette Yount Associates, 1992), p. 105, with permission of author.

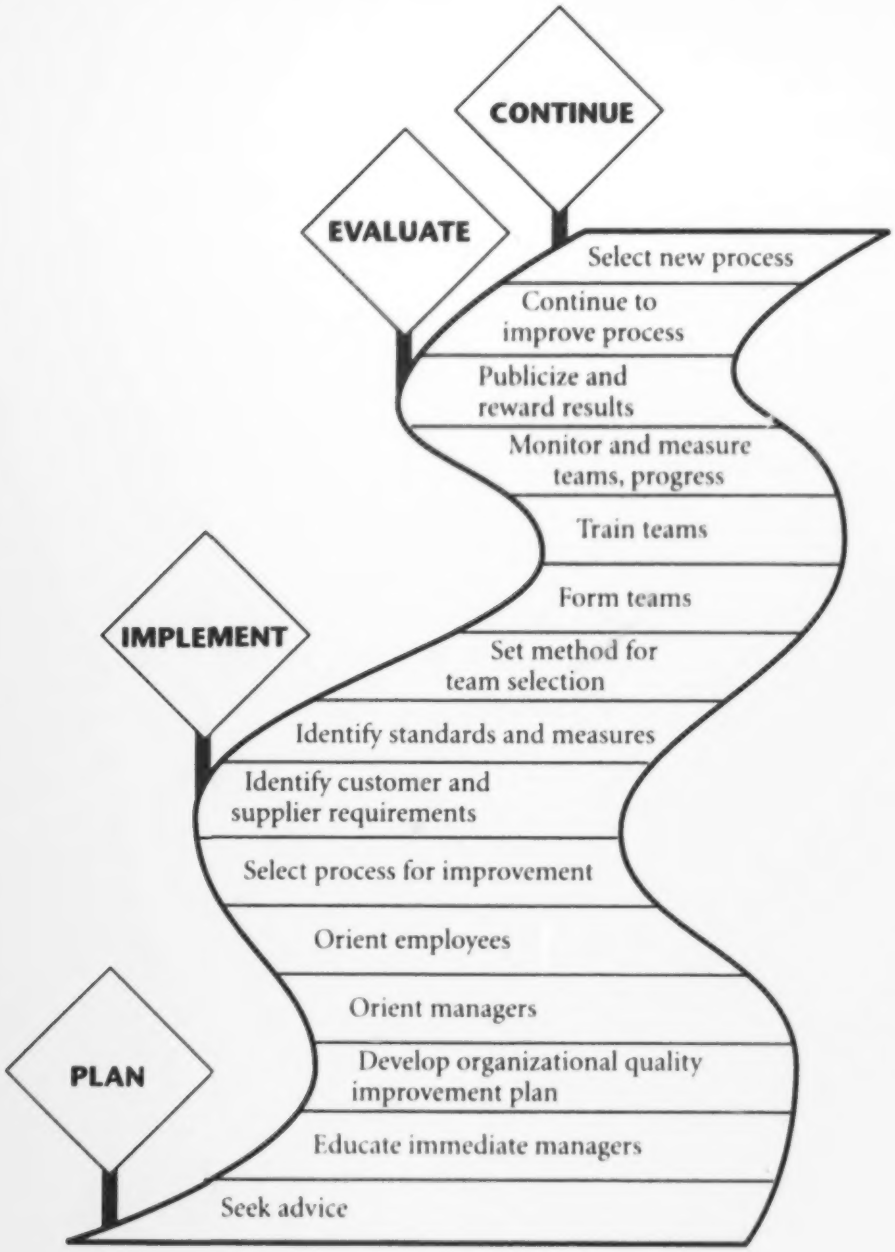


Figure 3.3
TQM Practice #3: Strategic Planning

Adapted from the Federal Quality Institute model.

- **Mission**. An agency's mission is what it is in business to do. Mission statements are generally short and concise. The mission of the organization should be measurable; the statement can be used to determine if the mission is being fulfilled. Following is the mission statement for the Woodbourne Center: "To strengthen the urban and school community with health, social services, and cultural programs that engage students and families in a lifelong learning process."
- **Vision**. An agency's vision is its dream, its ideal, and what it would see if everything were working perfectly. These statements are usually more general, far-reaching, and are not necessarily measurable. Example: "The vision of Woodbourne is to be the leader in creative services to families and communities."

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- **Values**. An agency's operating principles and practices, its ethics, and sometimes its goals, are included in the values statement. Following are excerpts from the values statements for the Woodbourne Center:

  > We value the relationships between children, families, and Woodbourne. We strongly believe that children and families are entitled to the best quality of care and services .... The Woodbourne Center believes in creating a positive and innovative work environment that anticipates the changing needs of our employees and volunteers .... We are committed to accomplishing this by fostering open communication, respect, and loyalty, while empowering staff, providing quality education, offering incentives, and supporting our employees' and volunteers' physical, emotional, and spiritual/ethical needs.

The preparation and publication of mission, vision, and values clarification statements is becoming widespread in American business and public agencies. Strategic plans are most effective when passed down to units with a tactical plan and with specific objectives that can be carried out by the work force. (An exemplary strategic plan methodology is found in Appendix A.)

Key points to remember about strategic planning: Mission, vision, and values clarification are usually done early in the TQM process. If an organization does not have meaningful direction, it cannot set achievable goals. It is management's responsibility to ensure that these statements are clear to employees and customers alike.

Summary

The role of management is crucial to the success of TQM. Management must be committed to the principles and practices for the effort to be effective, and ongoing commitment to and support of TQM initiatives is essential. Although there are many concepts that can be applied on an individual basis, the TQM philosophy will ultimately fail without the support of top leadership. Barriers to ongoing efforts include the following:

- Leadership issues,
- Employees not believing they are empowered,

- Employees lacking sufficient information on how to use TQM tools, and
- Employees lacking information and training on TQM concepts and theory.

Barriers will decrease as TQM involvement increases.

A key task of management is strategic planning—clarifying the organization's mission, envisioning what is possible, and choosing what to become. Subsequent planning is carried out with clear organizational goals that are sensitive to stakeholders and customers.

Exercise 3.1

Review the key management questions on page 31 from the perspective of your agency. How strong would you say your agency's management commitment is presently to embarking on TQM? Why?

Exercise 3.2

Use the definitions provided on pages 35-36 as references to answer the following questions.

1. Write out your own agency's mission as you presently understand it.

2. Write out a brief vision statement of the ideal or full potential of your agency if it could be achieved.

3. If everyone in your agency completed this exercise, how much agreement do you think you could find across your statements? Why?

Notes

1. J. Hodge-Williams, J. Anderson, and J. F. Spratley. "The role of the chief executive officer," In *Getting started with quality centered/team focused management* (unpublished manuscript). The chapter identifies and explores four tasks a CEO must undertake to successfully implement TQM: (1) create a learning organization, (2) build trust and commitment, (3) understand the importance of recognizing change, and (4) create an integration of one's personal and professional life.

4

Team Work and the Role of Employees

Employees must see themselves as empowered individuals and as contributors on teams to help make TQM successful in their organization. Using teams to identify and solve quality problems is a major TQM practice. This chapter reviews the use of teams in the quality improvement process and management's role in supporting team work.

The Employee's Role in Quality

Traditionally, employees have had no input or involvement in decision making in American organizations. Quality problems were attributed to the work force, so managers made all decisions and sent orders down the chain of command.

This is not an effective way of decision making, because important information gets left out of the loop. Also, finding someone to blame does not get to the heart of the problem. This process bypasses many people who may have contributed to the problem. At the core of TQM is the belief that all employees are responsible for analyzing work processes to find ways to prevent problems and work more effectively. Managers need to create the context and the structure for employees to be empowered to do this. Almost all organizations are now experimenting with better ways to obtain essential information and to involve employees in the business of the organization. The list below shows the various forms that individual employee involvement in quality can take in the organization:

- **Traditional suggestion box.** Employees usually consider this method useless.
- **Updated suggestion box.** This is a variation of the traditional suggestion box, includes the identification of a problem and a proposed solution, and is signed by the person making the suggestion; management guarantees a response.
- **Focus groups.** These are informal sessions designed to elicit feelings, thoughts, and opinions about work place problems.
- **Input groups.** These groups are specifically designed to give management input for decision making on a particular issue.
- **Quality circles.** These are decision-making teams authorized to solve quality-of-work life issues.
- **Quality improvement teams.** This type of decision-making team is authorized to solve work-related issues and improve work processes. QITs can be chartered to develop solutions and make recommendations to management for final approval and be fully empowered to select a project, create a team, identify problems, develop a solution and/or implement a solution.
- **Self-directed work teams.** This form of employee involvement calls for fully empowered employee teams that take on some traditional functions of management; such teams are radical models and are not widely utilized in American organizations.

These activities fit on a continuum, going from little involvement (suggestion box) to high involvement (self-directed work teams). In organizations committed to operating under a TQM philosophy, employees are responsible for a range of involvement activities. The kinds of activities typically included in successful TQM programs are presented below:

- Individual contributions,
- Team activities,
- Focus on quality and productivity improvement,

- Identification of problems/opportunities for improvement,
- Assuring well-defined work processes, and
- Training and support in the use of TQM techniques.

Teams are becoming a permanent and evolving fixture in efforts to achieve organizational excellence. The Quality Circle teams of the 1980s, for instance, have now been replaced by redesigned and more empowered work teams in the 1990s.

Consider this...

Old paradigm: People are a problem.

TQM paradigm: People are your greatest resource.

Empowering Employees for TQM

The quality improvement process and the delivery of excellent service can only be accomplished by empowered employees and teams, yet we know it is difficult to create a truly empowered work force. There are many obstacles that an organization must overcome. Empowerment is the bridge piece between the roles of managers and employees (see Figure 4.1). Both managers and employees must participate in empowering themselves and others and in driving this concept throughout the organization.

What Is Empowerment?

Empowerment means, "I *believe* in your ability to do the job and I *trust* you to do the job." Empowerment gives authority to the appropriate persons to solve problems on behalf of customers. It drives the decision-making power down through the organization. If employees are not empowered to build in quality at their points of service and to make decisions as needed, TQM will not be successful. Delegating problem solving to teams is another way in which management empowers employees. For example, it is through empowerment that employees can achieve this TQM slogan (that Crosby, in particular, emphasizes): "Do the right thing right the first time."[1] In TQM, then, empowerment is seen as the act of vesting appropriate authority in the hands of people nearest the problems to be solved.

Figure 4.1
TQM Practice #4: Employee Empowerment and Teamwork

Adapted from the Federal Quality Institute model.

Resistance to Empowerment

It is important to remember there can be resistance to empowerment. For example, managers are sometimes fearful of empowering employees. They believe that if they share or give their power away, they will lose it. Just the opposite is true—to be powerful you must give power away.

Supervisors fear, "The others will make mistakes, they'll give away too much, they won't need me anymore, I'll be out of control"; while employees fear, "I'll make mistakes, I'll get in trouble, I don't have the time to get involved, I don't know how to." Not everyone wants to be empowered—because empowerment requires risk, courage, independence, and the possibility of making mistakes. Some prefer to maintain the status quo, which is safe, quiet, and dependable.

In child welfare agencies, changes in staff expectations are of particular concern in implementing TQM. Child care workers who previously focused only on the child being treated must now take into consideration the family and community. Traditionally, child care

workers provided discreet segments of service over an extended time. Now, workers are involved in providing treatment or education virtually every moment. The increased responsibility and skill requirements placed on employees can be quite stressful.

Employees need appropriate training and a different, more shared approach to service responsibilities among coworkers and managers to effectively take on this new role. Thus, both management and employees have a responsibility to assure that workers are empowered to respond to customers competently and confidently. Outcomes at this point of customer service affect the entire organization's capability to provide quality service.

Following are **key points** to consider on empowerment:

- It is management's responsibility to enable empowerment and teamwork.
- Organizations empower people by vesting them with the appropriate authority to solve the problems that are close to them or that they are directly involved in.
- Individuals empower themselves by generating feelings of confidence that they can solve problems and act on behalf of customers.

A Team Work Focus for TQM

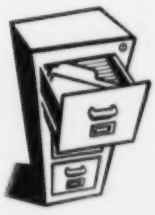
Much of the work in accomplishing the TQM effort is carried out in teams. Planning, Work Process Analysis (see Chapter 6), problem solving, and problem identification are usually done in teams. Six types of teams can be formed in an organization practicing TQM.

1. **Task forces** are formed around a specific purpose and are usually assigned by management for purpose of research or reporting.
2. **Quality circles** are formed for general purposes and usually focus on improving the quality of work life; membership is voluntary, generally meet weekly or biweekly; membership is usually within one organizational level.
3. **Quality improvement teams** are ongoing teams formed for the purpose of performing Work Process Analysis (see Chapter 6) and finding ways to increase quality; members may come from different levels, different divisions, and may include suppliers and/or customers.

4. **Project management teams** are usually appointed by management to specifically manage one project; membership varies.
5. **Management teams** are formed at the management level of the organization to address quality and/or management problems.
6. **Quality councils** are teams formed to provide oversight or TQM-specific planning; they may be called QCs, Quality Management Boards (QMBs), Quality Steering Committees, etc.

Teams are a vital element in TQM, but they are not the panacea for all quality needs. Managers and potential team members must ask the question, "Is this a good situation in which to use a team?" Below are some guidelines for when and when not to use a team:

When to Use Teams	*When Not to Use Teams*
A long-lasting solution is needed.	Time is the critical factor.
The problem is complex and seemingly unsolvable.	The situation is a crisis.
Different viewpoints are needed.	Decisions have low impact.
The impact of the problem is great and causes pain.	Team lacks resources to solve the problem.
There is sufficient time.	Outcome has been predetermined.
	An individual decision would be advisable.



Key points to consider in deciding whether to use teams, in addition to the ones listed above, include the following:

- **Advantages** of using teams
  - More information,
  - More experience, and
  - More perspective.
- **Disadvantages** of using teams
  - More time to make decisions,
  - More conflict (and more potential for interpersonal conflict), and
  - More personal compromise.

Identifying an Effective Team

Several factors differentiate a team from a group of people who simply work together. First, everyone on a team is committed to achieving the same task(s) and will take responsibility for the success or failure of that task. Second, someone on the team is responsible for group leadership and communication with management. Last, members may practice compromise and accommodation to get the needed input and agreement from all members for the needed solution. Effective teams do not just happen. They are developed intentionally in these ways:

- By learning how to work together (team-building knowledge, skills, and attitudes);
- By actively encouraging and appreciating the contributions of each other (producing *synergy*—a kind of dynamic that produces greater results than the combined individual contributions of all members); and
- By collectively agreeing on how they will work together to address the task and to maintain a constructive working relationship.

The best teams in every work setting have a lot in common. (A list of effective team characteristics is found in Appendix B.)

Current literature says that all teams are formed by management, and this is usually the case during TQM start-up. Some companies, though, are practicing other models, such as team self-formation around a particular problem, as illustrated in the list below:

Functional

- Formed by management or by employees within one function.
- Addresses improvement opportunities or processes that affect only that functional area.

Cross-Functional

- Formed by management from more than one work area.
- Addresses improvement opportunities or processes that impact on more than one functional area.
- Members represent any or all affected areas.

Task

- Members selected by management.
- Addresses specific issues that management identifies.
- Exists only to study/recommend/solve problems.

The team usually includes the team leader, team members, and a facilitator. In TQM teams, there is usually an ongoing, designated **Team Leader** who is also a full member of the team. This person is responsible for organizing meetings, providing for logistics, and being a link to management. Sometimes this person is chosen for content expertise. **Team Members** make up the team and usually number between five and eight. They do the work of the team and share various responsibilities for getting the job done. The **Facilitator** role is usually performed by someone external to the team. Facilitators are there to assist the team in its process and to provide the team with tools and techniques. They are sometimes called "Quality Advisors." As teams become skilled, this role is sometimes rotated among members of the team.

Each organization defines these terms and roles slightly differently. Membership in teams varies according to the type of team and its function. A task force may be made up of members from each division in the organization to get a cross view of a particular problem. Sometimes a team will consist of people from different levels within the same division. Teams can also include members from outside the organization. Sometimes suppliers or even customers are invited to join a team. Some teams are appointed, some are voluntary. Some are ongoing, others have a definite start and end point. They are called by many different names—Productivity Improvement Team (PIT), Productivity Assurance Team (PAT), Quality Improvement Team (QIT), Quality Assurance Team (QAT), etc.

Consider this...

Old paradigm: Manage people; solve problems as they arise.

TQM paradigm: Manage the process, not the people; the operation, not the results.

Middle management performs the central role in assuring teamwork is effectively implemented and supported through these activities:

- Establishing a process for identifying and selecting projects for improvement;
- Reviewing and monitoring work of quality teams;
- Establishing a process for appointing effective and appropriate team participants;
- Ensuring that participants are provided adequate time, support, and resources;
- Ensuring that training is provided;
- Insulating teams from organizational pressure;
- Promoting the quality improvement process; personally demonstrating support for team efforts;
- Tracking progress of implemented solutions; and
- Recognizing and rewarding accomplishments throughout the process.

For example, a child welfare agency implementing TQM might have the following results. The agency has enjoyed success with teams made up of employees who directly treat the children and do the technical planning. Managers have had good results focusing on treatment issues by getting feedback from the treatment teams rather than any one particular employee. Managers are also more intentional in viewing the child care workers as "experts" on a specific child's experience and in using those workers in that role for decision making. In this agency, child care workers themselves teach the managers ways the teams could better operate.

A **key point** to remember about management's role in team work is that the role of management is to support, encourage, and provide help to teams in procuring resources and in implementation. Teams report they feel "set adrift" when this support is missing. It is important for management to take an interest in the work of the teams. Structured support should come from the oversight group (QMB, etc.).

Summary

The traditional belief holds that employees are responsible for the problems in the organization. Research shows that the majority of problems (80% to 85%) are due to ineffective work processes. It is management's responsibility to go to the heart of the problems and avoid blaming employees.

Employees participate through teams to identify, analyze, and solve work quality problems (see Figure 4.2). Management ensures that teams have the necessary focus, development, and other support necessary for them to function effectively.

Exercise 4.1

The combination of empowerment and doing the right thing often leads to extraordinary service! Even though Deming says to eliminate slogans, because organizations tend to rely on exhortations rather than taking action to make the needed changes in their systems, this is one of the common slogans used in the TQM literature. It is sometimes stated, "Do the right thing right, the first time and every time." Some employees have added, "on time." This slogan focuses on preventing errors, rather than correcting them, and on continually creating quality.

1. What does the phrase, "Do the right thing right the first time," mean to you?

2. Does this slogan have positive or negative connotations for you?

Figure 4.2
The Total Quality Management Journey: The Employee's Role

From L. Yount, *Total Quality Management: An Overview* (Arlington, VA: Lynnette Yount Associates, 1992), p. 106, with permission of author.

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3. How might empowerment affect the implementation of TQM in your agency (i.e., meeting customer requirements, having effective work processes, knowing the parameters within which one is authorized to make decisions, communicating with colleagues)?

Note: The slogan above is about empowerment and acting on behalf of customers. It is *not* about never making mistakes or rigid perfectionism. Some people hear it as a ban on errors and therefore feel constricted by it. Making mistakes, *and* finding ways to correct and/or improve them, is an inherent part of the learning process in TQM. This process leads to continuous improvement.

You can contrast the slogan with the statement that is often posted over secretarial workers' desks: "There's never enough time to do it right, but there's always enough time to do it over." This has been the silent protest for years of support staff—asking for the proper time up front for planning, communicating instructions, providing proper resources, and help if needed—as opposed to ill-conceived, poorly communicated tasks that waste time and lower the esteem and commitment level of those attempting to carry them out.

4. Identify empowering actions that employees or managers in your agency can take.

Exercise 4.2

1. What kinds of teams has your agency used in the last few years?

2. How positive or negative is your agency's experience in using teams?

3. Why do you think your agency's teams have succeeded as well as they have, or been as unsuccessful as they have?

Notes

1. P. B. Crosby, *Quality without tears* (New York: McGraw-Hill Book Company, 1985), p. 59.

5

Continuous Quality Improvement and Measurement

This chapter covers one of the most important aspects of TQM—*Continuous Quality Improvement* (CQI). The CQI process identifies different kinds of quality problems that can be worked on and emphasizes the importance of going to the root cause of those problems. The following sections address management's role in continually improving work processes. Finally, the chapter presents one approach to work process improvement: the Plan—Do—Check—Act Cycle.

Continuous Quality Improvement

Organizations *not only* must produce high-quality services and goods, but they must also *not* be content with maintaining the status quo. In fact, in an era of rapidly advancing technology and increasing demands, any organization that chooses to bury its head in the sand will surely not survive in today's fast-changing world.

There are many reasons why we cling to the old and hold on to the status quo. Change brings confusion, fear, and uncertainty. Many of us feel comfortable avoiding change. Change, however, is now a certainty. Because of a shrinking world economy and rapidly advancing technology, there will probably never again be long periods of stability in our culture; therefore, we must grow comfortable *with* change. One TQM saying goes, "The most effective way to cope with change is to help create it." The way to *attract* our customers is to provide them with high-quality products and services; the way to *keep* our customers is to provide them with ever-improving goods and dazzle them with superior service—in effect, creating change.

American business especially has had to undergo significant change and innovation in recent years. There is the tendency in America to believe in miracles, breakthroughs, and quantum leaps to solve our problems. Quick results and high technology, however, are not the main approaches to achieving TQM.

The Japanese concept *Kaizen* means "small improvements made in the status quo as a result of ongoing efforts." The Japanese believe that little by little, small improvements add up over time to continual success.[1] Masaaki Imai believed *Kaizen* to be the single most important concept in Japanese management that contributed to Japan's phenomenal success. Remember one of Deming's 14 points from Chapter 1: "Improve constantly and forever the system of production and service." Peters indicates the most efficient and effective route to bold change is the participation of everyone, everyday in incremental steps.[2] (Tom Peters is probably the best-known and most widely read American author and consultant on current business patterns and emerging trends.)

There is nothing inherently wrong with the traditional American approach—in fact, we have made some of the most exciting advances in the 20th century this way. We tend to miss many opportunities, however, when we only use this approach to the exclusion of the *Kaizen* approach.

Consider this...

Old paradigm: Improvement means major breakthroughs; it proceeds in quantum leaps.

TQM paradigm: Improvement means a continuous series of small gains; it proceeds incrementally.

So what is the importance of continually improving our work processes? In public service, improved productivity results in the ability to capture a reputation for distinction in service excellence, the ability to stabilize the work force and justify budget innovations, and an agency mission that can be sustained. A key point to remember about continuous improvement is that performance improvement goals will foster continuous improvement. Managers at the senior level should set these goals, which reflect strategic choices about the critical processes for survival of the organization. A caution exists here as well—Deming advocates eliminating fear and abolishing production quotas. He also states that it is useless to establish goals without methods of achieving them.[3]

The Cost of Quality

Historically, American managers have believed in the myth that the following trade-off exists between quality and productivity:

Improve Quality = Increase Cost = Decrease in Productivity

The cost of lack of attention to quality has been enormous to American organizations, because focusing on short-term gain prevents slow, incremental improvement and growth. Presented below are some statistics developed by the Federal Quality Institute on the work process.

10%—Necessary but non-value-added

30%—Unnecessary work (rework)

10%—Unnecessary work (not needed)

25%—Not working (This time can be used for team meetings, without taking away from productivity.)

25%—Value-added work

These statistics include the three main elements that Work Process Analysis looks at: unnecessary work, rework, and value-added work.[4] (These concepts will be discussed in detail in Chapter 6.) *Business Week* magazine's assessment of this situation goes even further:

> As many as one-quarter of all factory hands don't produce anything—they just rework things that were not done right the first time. Add in the expense of repairing or replacing the flawed products that slip out of the factory and into the market, and the total burden of "unquality" can amount to a punishing 30% or more of production costs.[5]

While these figures raise a general concern for many managers, these individuals still prove resistant to the idea that their unit is included in the "unquality" issue. They point rather to problems elsewhere in the system that directly and adversely affect the quality of their unit's performance. Managers may also not be willing to openly proclaim mistakes for fear of reprisal to themselves or employees. Most organizations still focus on sanctions for admitting mistakes, rather than incentives to find and eliminate mistakes.

A helpful way to assess the limitations of an organization's cost containment approach is to determine its emphasis in each of the three components of the cost of quality—prevention, appraisal, and failure:

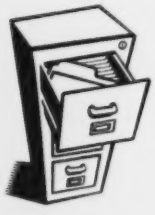
1. **Prevention.** Preventing nonconformance to customer requirements.
2. **Appraisal.** Inspecting outputs to ensure conformance to customer requirements.
3. **Failure**—Redoing, correcting, or scrapping outputs that do not conform to customer requirements.

Organizations' efforts to achieve quality range from effective to ineffective depending, in part, on their choices among these components. The prevention tasks—planning, training, process analysis, defect analysis, testing procedures, and pilot programs—are costly, but if these tasks are done correctly, they eliminate and/or decrease costs in the other two categories. TQM promotes spending money on prevention to do it right the first time.

The traditional paradigm delegates quality control to one person or department. This is not only a costly and extremely inefficient way of maintaining quality, it also removes responsibility and pride in workmanship from employees. This approach systemically leads to redoing, reworking, correcting errors, redrawing, scrapping, answering complaints, creating products that fail, and increasing costs. Deming advocates eliminating end-of-production inspections. The alternative is to build quality in at every point of the process.

An example from a quasi-government financial organization illustrates the cost of quality concept stunningly. The organization adopted a TQM approach and in *the pilot phase* of their TQM project, through Work Process Analysis, discovered that an entire department (approximately 100 people) was operating to handle complaints and delays created by one glitch in the system. Management has recommended eliminating the glitch, which will remove the need for the entire department. Think of the savings![6]

You may ask, "What will happen to those 100 employees?" The TQM approach suggests that *more jobs* are created, not less. Hopefully, these 100 people were transferred to other departments whose workloads will increase, due to the added capacity from the elimination of a major problem in the system.



A **key point** to remember about the cost of quality is that, to obtain the maximum efficiency in quality products and services, the investment in prevention will need to far outweigh the cost of cleaning up failures. Even though public service agencies are not in business

to save money, every organization is concerned with cutting costs and maximizing the dollars they still have. The following list compares the benefits of high quality with the costs of poor quality.

Benefits of High Quality	*Costs of Poor Quality*
Improved Quality of Services	Extensive Waste
Improved Quality of Work Life	Duplication of Effort
Increased Productivity	Employee Grievances
Increased Revenue	High Turnover of Staff
Increased Customer Satisfaction	Lack of Teamwork
Enhanced Competitive Position	Lost Customers
Reduced Expenses	Poor Productivity
Reduced Waste	Increased Staff Frustration
Increased Employee Commitment	Missed Deadlines and Schedules
Increased Employee Morale	Increased Disability Pay

Measurement and Analysis

TQM advocates making continuous improvement decisions based on data.[7] The initial step is agreeing on what to measure within the work processes of the organization (see Figure 5.1).

This section reviews the traditional and TQM approaches to measuring and analyzing performance problems. It also provides an improved model for applying data measurement in an organization to continuously improve productivity.

Problem Identification

In making work process improvements, an organization must first clearly identify problems. Problems can be identified in different ways and may range from small specific items to entire work processes.

Employee involvement is critical to the identification of problems. Usually workers are more acquainted with operations' problems associated with service and production. Remember from Chapter 4 that methods for submitting problems range from the suggestion box to participation in a quality improvement team. In TQM, management usually decides how problems will be gathered, sorted, and distributed for solving. One approach is to form a group that only receives problems and decides where they should be addressed. Some problems are determined to be solvable by an individual/expert, some go to employee-

Figure 5.1
TQM Practice #5: Measurement and Analysis

Adapted from the Federal Quality Institute model.

level teams, others go to management-level teams, some to newly formed, cross-functional quality improvement teams.

- **The traditional approach to problem identification.** The traditional approach to identifying problems is *detection*—finding problems after they occur. For products, this results in inspections and other quality control methods that require a decision to be made about whether to use the product, rework it, or scrap it. An inspection system is usually unreliable, and often customers receive defective products. This results in more cost as the customer returns the item, and staff handle the complaint and reship a new product. The traditional view also holds that problems are headaches and failures.

- **The TQM approach to problem identification.** The TQM approach encourages the *prevention* model—detecting

problems before they occur, or before they become systemic and costly. The prevention model precludes problems from occurring through planning.

The TQM view is that problems are opportunities for quality improvement. Recall the story of Thomas Edison and his numerous attempts to find the right filament material for the electric light bulb. A colleague remarked, "It must be discouraging to have failed 167 times." Edison responded, "I haven't failed. I have discovered 167 ways it won't work." We all know his final results.

One of the challenges of adopting the TQM approach is to change the corporate culture to view problems as "quality challenges." While doing research for their book, *Leaders*, Bennis and Nanus discovered a surprising similarity between the 100 successful organization heads the authors interviewed: the word "failure" was not in anyone's vocabulary. They all saw problems as improvement opportunities.[8]

One of the important TQM concepts regarding problem solving is the Quick Fix versus the Root Cause. Many organizations operate in the crisis and bandage mode. As problems arise they are "fixed." Minor problems receive a bandage, and major problems get addressed with much sound and fury. Getting to the bottom of the problem, however, is seldom done—often because so much energy is spent in putting out fires. The problems are likely to resurface if nothing is done to correct them.

TQM locates the root cause of the problem. Instead of finding fast solutions, teams look to the data and the work process to discover the real problem. Sometimes this means looking to the process or department that precedes yours. As you will see later in Chapter 6, problem solvers are encouraged to question "why?" five times and to examine all angles of the situation. Following is an example of how staff at a TQM-oriented car manufacturer determined the root cause of a machine stoppage:

Question 1: Why did the machine stop?
Answer 1: Because the fuse blew due to an overload.
Question 2: Why was there an overload?
Answer 2: Because the bearing lubrication was inadequate.
Question 3: Why was the lubrication inadequate?
Answer 3: Because the lubrication pump was not functioning right.
Question 4: Why wasn't the lubricating pump working right?
Answer 4: Because the pump axle was worn out.
Question 5: Why was it worn out?
Answer 5: Because sludge got in.

Solution: Attach a strainer to the lubricating pump.

The PDCA Work Improvement Cycle

The Plan—Do—Check—Act (PDCA) Cycle was developed by Shewhart in the earlier part of this century.[9] (Walter Shewhart, a mentor of W. Edward Deming, was a highly respected statistician and researcher who developed numerous methods of statistical quality control. These methods were pioneering in many respects, including allowing employees to measure and make adjustments to their own work.) This model is an application of the scientific method to continuous process improvement and shows the main steps in the cycle of productivity. The PDCA Cycle is sometimes shown as a turning wheel to imply continuous, ongoing improvement, without a discreet beginning (see Figure 5.2).

The four components are defined as follows:

- **Plan:** Document the current status of the process, collect data to identify and define problems, and plan specific actions to improve the process.
- **Do:** Implement the plan, on a pilot basis when possible; collect data on the process and the plan; employ statistical process measurements.
- **Check:** Evaluate the data and determine if the plan has worked and if the process has been improved.
- **Act:** If data show process has improved, standardize the change; if improvement did not occur, recycle through PDCA.

PDCA Cycle—The Traditional American Way

In the traditional American way of functioning, we usually start by Doing, and we typically separate planning from doing—managers plan and employees do (see Figure 5.3). This creates a lot of reinventing the wheel and going back to square one. Recall the Customer/Supplier training exercise discussed in Chapter 2 on pages 23-24—many "suppliers" proceeded straight to Do without clarifying requirements or assumptions (Planning) of their "customers."

A common complaint from supervisors and managers is, "We do not have time to plan." That is an especially familiar litany in service agencies and the government, because of shrinking budgets, changing work force, and increasing demands. This attitude, however, costs millions in waste, rework, scrap work, etc.

Figure 5.2
The PDCA Work Improvement Cycle

From L. Yount, *Total Quality Management: An Overview* (Arlington, VA: Lynnette Yount Associates, 1993), p. 11, with permission of author.

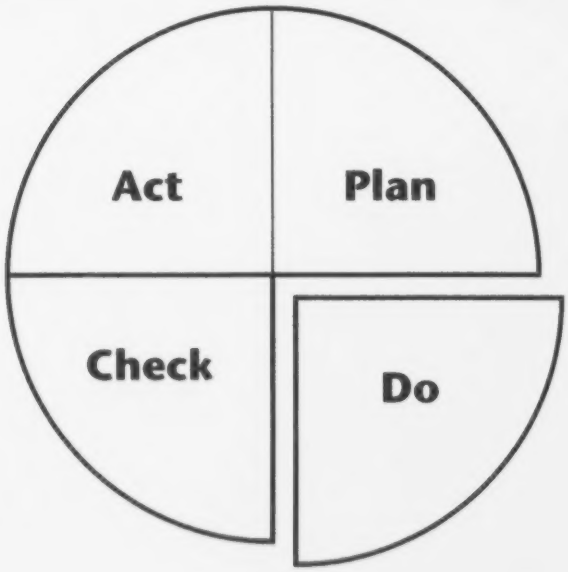
PDCA Cycle—The TQM Way

The TQM variation of the PDCA Cycle states that, before the cycles begin, people must first understand the Big Picture. This means clarifying the intention of the *work process* undergoing improvement by the "doers" with the mission and vision of the *organization* (see Figure 5.4) This is done before the Planning step by communicating with customers and management.

The need for effective and efficient planning for child welfare agencies is increasingly critical in the area of client record and documentation. Employees and managers will have to become better document keepers of client work approaches and measurers of outcomes. An agency's many departmental and program planning efforts will be difficult to coordinate without a sound, universal approach everyone supports and finds effective over time.

Figure 5.3
PDCA Work Cycle—The American Way

From L. Yount, *Total Quality Management: An Overview* (Arlington, VA: Lynnette Yount Associates, 1993), p. 12, with permission of author.



Consider this...

Old paradigm: Make decisions based on hopes and hunches.

TQM paradigm: Make decisions based on data.

Summary

Continuous Quality Improvement (CQI) is the systematic, ongoing, organization-wide approach to making all processes of service and product delivery capable of meeting customer requirements. CQI must accomplish this and sustain the necessary levels of quality with the allotted resources of the organization. Paramount to an organization's pursuit of continuous quality improvement are the following elements:

Figure 5.4
PDCA Work Cycle—The TQM Style

From L. Yount, *Total Quality Management: An Overview* (Arlington, VA: Lynnette Yount Associates, 1993), p. 13, with permission of author.

- Development of strong customer (internal and external) knowledge;
- An organization attitude of not being satisfied with how we are doing—ever;
- Constant effort to align all work processes;
- A commitment to innovation versus refinement only; and
- Continuous learning from employees, customers, suppliers, and stakeholders about the organization's products, services, and work processes to improve decisions.

Exercise 5.1

1. Does your organization have a "complaint department" or similar arrangement? Describe.

2. How much of your time do you estimate is taken with this kind of work? Explain.

Exercise 5.2

There was a big retirement party in your office today, and your telephones were not covered for a total of three hours, from 11:00 A.M. to 2:00 P.M. Customers have been calling all afternoon complaining.

1. What can you do now?

2. What could you have done before this point?

3. What might be the real cause of this problem?

Notes

1. M. Imai. *Kaizen: The key to Japanese competitive success* (New York: Random House, 1986).
2. T. J. Peters. *Thriving on chaos: Handbook for management revolution* (New York: Harper & Row, Publishers, 1988).
3. Adapted from M. Walton. *The Deming management method.* (New York: Putnam Publishing Group, 1986).
4. From material distributed by the Federal Quality Institute, Office of Personnel Management to all Federal agencies, 1990-5. The FQI no longer exists and materials are unavailable.
5. Reprinted from the June 8, 1987, issue of *Business Week*, p. 132. © 1987 by McGraw-Hill Companies.
6. Personal story related to Lynnette Yount by a staff member of a large Federal agency that dealt with financial matters, 1991.
7. J. Hodge-Williams, J. Anderson, and J. F. Spratley, *Getting started with quality centered/team focused management* (unpublished manuscript).
8. Adapted from W. Bennis, & B. Nanus. *Leaders: The strategy for taking charge.* (New York: Harper & Row Publishers, 1985).
9. M. Walton, *The Deming management method.* (New York: Putnam Publishing Group, 1986).

TQM Work Process Analysis

Defining Work Process Analysis

Every work process that occurs within the organization will eventually be analyzed for unnecessary work, value-added work, and accountability. (Value-added work is any contribution to a product or service by an employee, which adds worth or importance to the ultimate output provided to the customer.) An employee who attaches a taillight to a car chassis on the assembly line adds value. An employee who has to replace a taillight that does not light up is performing non-value-added work. That task is duplicative and unnecessary, because the taillight could have been installed right the first time.

Work Process Analysis is a fundamental TQM method for improving and/or redesigning work processes, and solving quality problems. (Random House Dictionary defines *process* as "a systematic series of actions directed to some end; a series of progressive and interdependent steps by which an end is attained.")[1] TQM focuses on *managing and improving processes* as the way to achieve quality. To *improve* a process, an organization analyzes that process, identifies problems, and finds solutions for eliminating unnecessary work and adding value-added activity.

Statistical Process Analysis and problem solving are two methods used to carry out Work Process Analysis. This chapter reviews these methods and discusses the basic tools used within each.

Work Process Analysis, sometimes referred to as WPA, is a structured approach to quality improvement. It involves a step-by-step process that includes problem identification, analysis, and documentation,

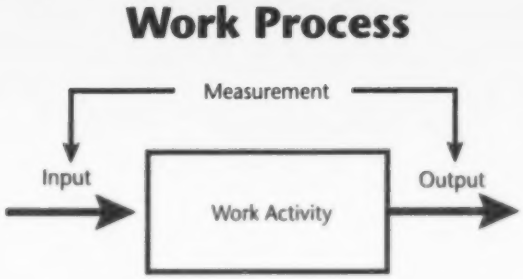
culminating in problem solving. The analysis focuses on one or more work processes that employees of the organization use to produce their services and products. (Work Process may be defined as the organization of people, procedures, equipment, and materials into work activities needed to produce the specified result—the work product.) A Work Process *Analysis* has four requirements:

1. **Identify work-based problems.** As indicated in Chapter 5, this is usually the first step to improving a process. Sometimes a team is formed because a problem has been identified, and the vehicle to address that problem becomes WPA.
2. **Set realistic standards.** American managers often set arbitrary goals for productivity improvement, and employees are then rated on their ability to reach quotas—realistic or not. Deming, in particular, warns against this approach, noting a worker cannot be expected to do it right the first time when the materials that he has to work with are defective, equipment malfunctions or is the wrong type, or the supervision that he is forced to work under is incompetent.
3. **Use quality improvement methodology.** This means using the tools and techniques of TQM—structured approaches to problem solving, Statistical Process Control (SPC), team building techniques, etc.
4. **Improve continuously.** Periodically check back with customers, employees, and the hard data to make sure quality is sustained and customers are delighted. Obtain accurate measurements through surveys, assessments, and especially SPC.

The Components of Work Process Analysis

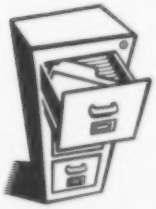
Figure 6.1 illustrates the relationship of the components of a work process needed to add value to an organization's service or product. Traditionally, the components are input, activity, and output. **Input** is the materials, people, processes, machines, etc., that affect the process. These are provided by *suppliers.* An **Activity** is a series of interrelated steps that result in output: product, service, or action. Steps are performed by *operators/employees.* **Output** is the results of completed process, which may then be used as input to a subsequent process. Outputs are received by *customers.*

Figure 6.1
The Components of the Work Process Analysis



TQM adds to this traditional process the element of *measurement,* which occurs in all three phases. Employees, for example, may keep written records on the timeliness of supplies received, the number of items produced per hour, and the number of complaints and testimonials received from customers.

A system consists of several processes. A process usually consists of several steps with a number of substeps. Steps are sometimes called *tasks,* and substeps, *activities.* For example, the Personnel System includes the following Processes (Steps): the hiring process; orientation process; technical training processes; job performance appraisal process; payment of wages, fringe benefits, and taxes processes; and employee firing processes. Within the Hiring System there are the following *Substeps* (Activities): writing duties and responsibilities, posting vacancy announcements, accepting applications, choosing final group, conducting interviews, and recommending a candidate.



A **key point** to consider in Work Process Analysis is that to *manage* the process means to understand how it all works—its boundaries, interfaces, capabilities, and its customers and suppliers.

Statistical Process Control

Statistical Process Control (SPC) is a set of procedures using statistical measurement and identification techniques to determine if processes are "in control." That is, are the results sustained at the level needed to meet the customer requirements? Sometimes the term Statistical Quality Control (SQC) is used. In the 1950s and 1960s in this country, the use

of SPC practically ceased but then made a comeback in the 1970s, when American businesses were forced to turn to Japan and other countries for management assistance to regain their competitive edge. We "rediscovered" how SPC could assist the production process and help build in quality from the front end.

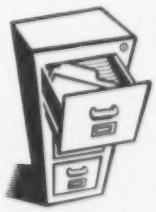
The basic tools of SPC are easy to learn and to use. (A middle high school-level understanding of mathematics and problem solving will typically be sufficient.) When an organization needs more sophisticated data gathering and analysis techniques, it may call upon an in-house statistician.

SPC helps to identify problems quickly and accurately. It also provides quantifiable data for analysis and provides baseline data for measurement purposes. In the context of TQM, using SPC on a continual basis also accomplishes other things—worker involvement, better use of resources, data-based decision making, and of course, higher quality. There are more than 40 tools and techniques that can be used for measurement of all kinds. We will discuss the eight basic tools that are most frequently used.

Check Sheet

The first step in the application of TQM tools is data gathering. Problem identification and analysis all stem from the availability of meaningful information that teams can then assess. SPC typically uses four forms of data gathering: check sheets, surveys or samples, questionnaires, and focus groups.

We will address only the Check Sheet here. See the reading list in Appendix C for sources of information on surveys, questionnaires, and focus groups.



A Check Sheet is an easily accessible way to gather data and to track how often things are happening by keeping a tally (see Figure 6.2). A Check Sheet begins the process of translating hunches or opinions into data and facts. An organization can then use these data to identify problems (see Chapter 5). A **key point** to remember: Check Sheets answer the question, "How often are certain events occurring?"

Figure 6.2
Check Sheet

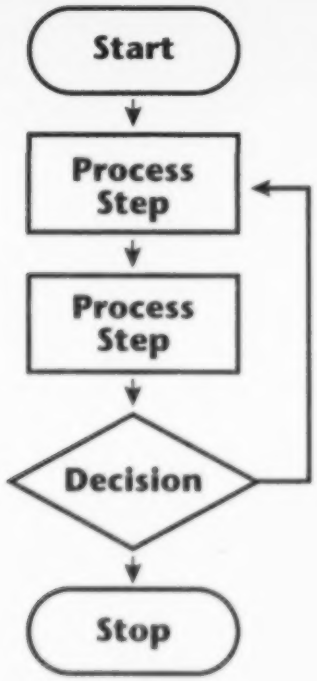
Event	Date			Total
	1	2	3	
Centering	|	|	𝍸	7
Spelling	𝍸 |	𝍸 ||	𝍸 |	19
Punctuation	𝍸	|||	𝍸	13
Total	12	11	16	39

Flow Chart

When conducting an analysis of a work process problem, it is useful to prepare a *Flow Chart* of that process. To do this, we need to understand work flow. Work Flow Analysis (WFA) is a sequential identification of the various steps, including inputs and outputs, that are involved in the performance of specific tasks or activities within a process. Simple processes can be diagrammed with all the steps. Complex processes require several diagrams as each step is diagrammed in substeps.

The Flow Chart is helpful for identifying and studying everything that occurs in a process, including the start and end points (see Figure 6.3). Sometimes processes are dramatically improved just by the use of a Flow Chart alone. When all the activities, tasks, or steps are recorded on the Flow Chart, the organization can then identify problems and then eliminate, redesign, or streamline wasted steps to improve the process. An added benefit is that, once completed, a Flow Chart is an excellent orientation tool for new employees.

Figure 6.3
Flow Chart



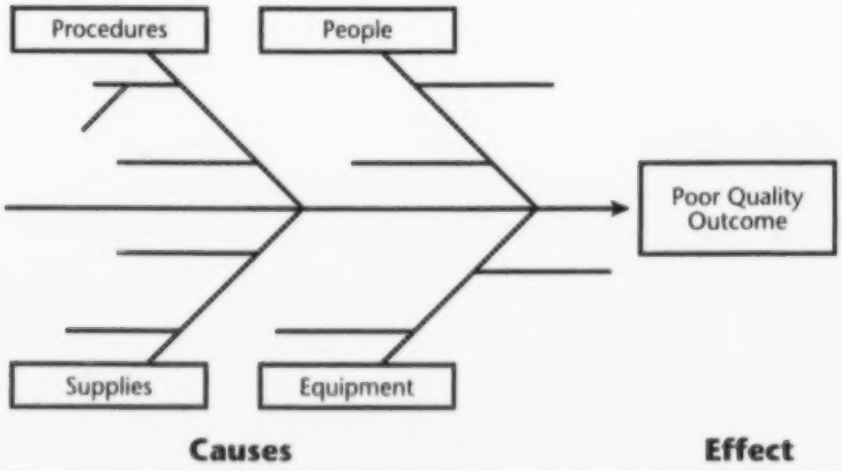
Flow Charts are usually diagrammed using standardized symbols for different aspects of the process. Circles or ovals indicate start and end points, boxes indicate process activities, and diamonds indicate decision points. Arrows show how the work proceeds, how rework is carried out, and where gaps occur. A **key point** to remember: Flow Charts answer the question, "What are the major steps in the process?" Flow Charts are an effective way to illustrate various tasks:

- To clarify and verify the steps of a process,
- To understand the "whole" picture,
- To identify customer/supplier relationships,
- To identify problem areas and complexities,
- To identify value-added work,
- To stimulate ideas/areas for process improvement, and
- To identify areas for additional data collection.

Cause-and-Effect Diagram

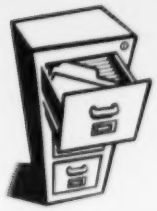
The *Cause-and-Effect Diagram*, popularly called the "fishbone," was created by Kaoru Ishikawa in 1952 to aid in Work Process Analysis.[2] It may be familiar to some readers; it was used frequently in Quality Circle programs. The diagram represents the relationship between an effect or problem and its possible causes (see Figure 6.4).

Figure 6.4
Cause-and-Effect Diagram



Possible causes are listed by categories to the left of the problem, or *effect*, box. Subcategories may be added by drawing an additional line. Each "branch" off a subcategory is identified in response to the question, "Why did this problem occur?" By working this way along each branch as far as they can, Quality Improvement Team members may uncover possible *root causes*, or fundamental reasons for the problem. The following combinations reflect the most common categories:

- **4 M's (or 3 M's + P)** = Manpower, material, machines, methods (the word "people" is frequently being substituted for manpower to use inclusive language).
- **4 P's** = Policies, procedures, people, plant, and/or planning.
- **PEPSE** = People, procedures, supplies, and equipment.



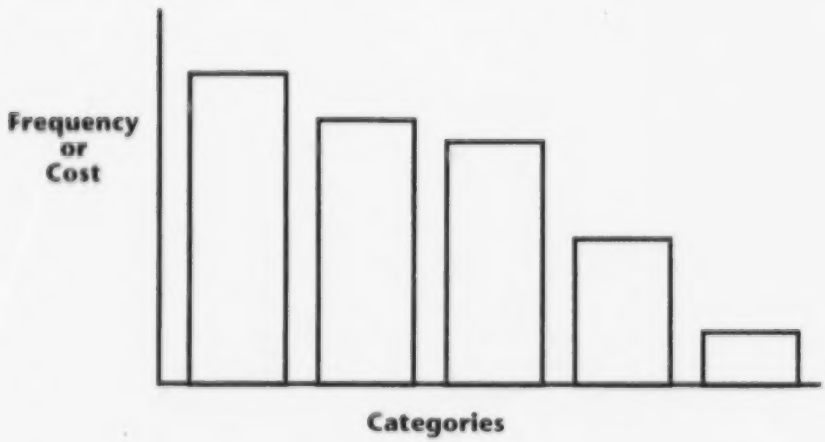
A **key point** to remember: Cause-and-Effect Diagrams answer the question, "What could be causing this effect?" and so can help organizations with these tasks:

- Organize and focus the team's knowledge of a process.
- Define the possible causes of a problem or effect.
- Discriminate between *causes* and *symptoms.* (Symptoms are the results of a problem that produces negative consequences which the customer, and perhaps employee, detects. An example is a leaky faucet in a restaurant washroom. Causes are the ultimate source of a problem, e.g., a faulty procedure, manufacturing step, or inadequate materials. The cause of the faucet symptom is a worn washer in the spigot.)

Pareto Chart

Juran coined the terms "vital few" and "trivial many."[3] The *Pareto Chart* shows graphically which problems are the "vital few" and therefore points to which problems need to be addressed by displaying the relative importance in terms of frequency of occurrence or cost of several problems or causes in a bar graph (see Figure 6.5).

Figure 6.5
Pareto Chart



The magnitude or frequency of occurrence of variables is shown in descending order from left to right on the horizontal axis. The vertical axis indicates numbers—usually totals, percentages, or dollar cost. Following are the nine steps for making a Pareto Chart:

1. Collect the required data.
2. Define the categories to be used in the analysis.
3. Arrange the data in order, from the largest category to smallest.
4. Calculate the total.
5. Compute the percent of the total that each category represents.
6. Construct a bar graph by drawing axes, recording categories on the horizontal axis, and quantities or frequencies on the vertical axis.
7. Scale the axes.
8. Working from left to right, construct a bar for each category, with height indicating the frequency or quantity. Start with the largest category and add others in descending order.
9. Plot the cumulative percent line.

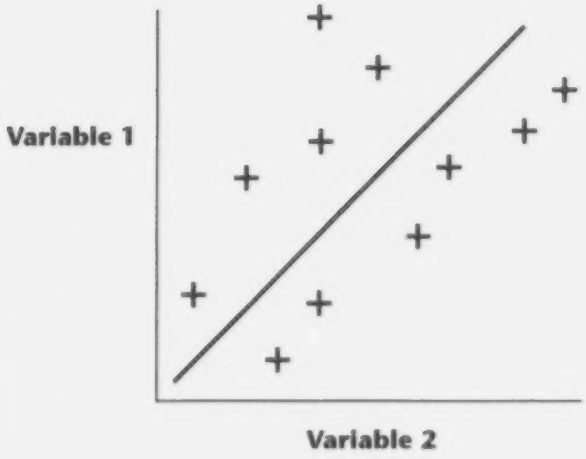
A **key point** to remember: Pareto Charts answer the question, "Which problem shall we work on?" Organizations may use Pareto Charts for these tasks:

- To choose a starting point for problem analysis by identifying the most important problem;
- To analyze different groupings of data (e.g., by product, by unit, by case);
- To prioritize problems; and
- To measure impact of changes made in a process.

Scatter Diagram

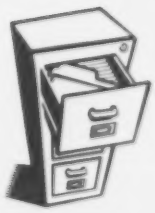
A *Scatter Diagram* is used to study the possible relationship, or correlation, between two variables or characteristics of a work process. Scatter Diagrams indicate what occurs to one variable when another is changed (see Figure 6.6); they do not prove that one variable causes the other, but rather, whether a relationship exists and how strong it is.

Figure 6.6
Scatter Diagram



The dots in a scatter diagram may come out in one of three patterns. The tighter the dots are clustered, the stronger the correlation. The farther the dots are from the "line," the weaker the correlation:

- **No correlation**. Dots will be randomly scattered around the graph.
- **Positive correlation**. Dots form a relatively straight line from the lower left corner to the upper right corner; this occurs when the larger values of one variable correspond to the larger values of the other.
- **Negative correlation**. Dots form a line from the upper left corner running down to the lower right corner; this occurs when the larger values of one variable correspond to the smaller values of the other.



A **key point** to remember: Scatter Diagrams answer the question, "Is there a relationship between variables?" Organizations may use Scatter Diagrams to test for possible cause-and-effect relationships, study the correlation between two variables, and demonstrate the strength of the relationship.

Histogram

A *Histogram* helps to check the way a work process is currently operating. It can also be used to identify changes that may have occurred as a result of an improvement effort. The Histogram shows the range of variation occurring in a process (see Figure 6.7). No matter how concise a process, some variation will occur. In manufacturing, the acceptable level of variation is measured using the standard deviation and is called *tolerance.* In service organizations, variation will occur depending on who is doing the work, different personalities, customers, styles, etc.

Figure 6.7
Histogram

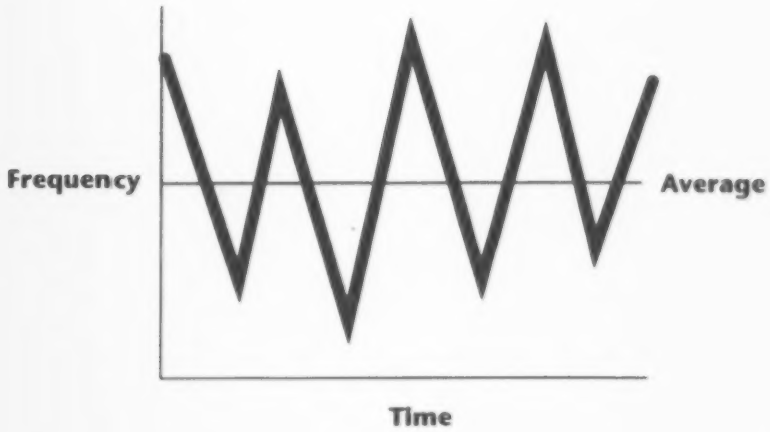
A Histogram is really a special form of a bar graph that shows *frequency distribution*—the distribution of variation within a process. If the Histogram does not look normal or bell shaped, it is a signal to examine the process. An organization cannot afford to live with wildly varying results from day to day.

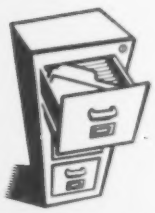
A **key point** to remember: Histograms answer the question, "How much variation exists in a process?" Use a Histogram to measure amount and distribution of variation, determine how well a process is functioning, and measure effects of changes to a process.

Run Chart

The *Run Chart* is the simplest tool to construct and is also the most familiar (see Figure 6.8). It is frequently used to plot things like change in mortgage rates, birth and death rates, inflation rates, etc. It is sometimes called a *Trend Chart*. Run Charts measure things over time. They are used to indicate whether there is a pattern, trend, or change over a particular amount of time.

Figure 6.8
Run Chart



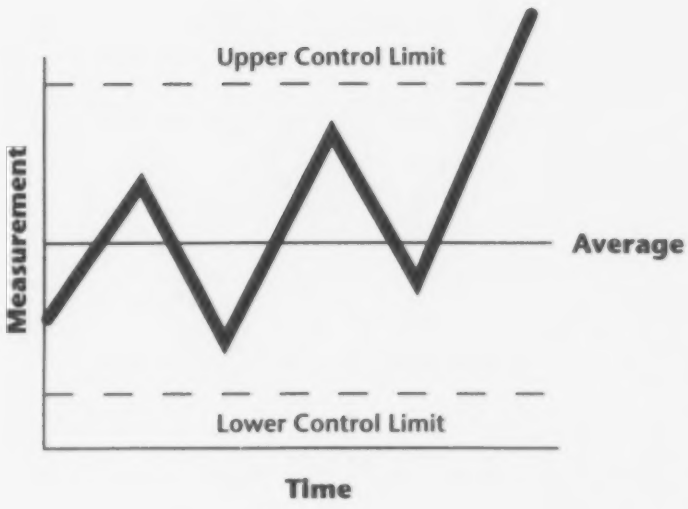


A **key point** to remember: Run Charts answer the question, "Is there a trend over time?" Use Run Charts to illustrate trends over time, understand basic characteristics of a process, and focus attention on truly vital changes in the system.

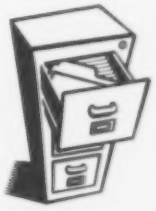
Control Chart

A *Control Chart* is actually a Run Chart with upper and lower control limits added. This is the tool that specifically identifies the measurements for Statistical Process Control. It helps to determine how much variation exists in a process. A Control Chart's upper and lower control limits (UCL and LCL) are calculated by running a work process untouched, taking samples and determining the standard deviation (see Figure 6.9).

Figure 6.9
Control Chart



Control Charts indicate if a process is in control, or stable, but do not indicate whether it is meeting customer requirements—for example, the process may be yielding a consistently poor product. If a process is in control, but not meeting requirements, management must decide either to improve the process or renegotiate the specifications with the customer.



A **key point** to remember: Control Charts answer the question, "Is the process in control?" Use Control Charts to determine how much variation exists in a process, and evaluate when action should be taken to correct variations.

Problem Solving

After problems and processes have been thoroughly analyzed, measured, and documented, the quality improvement process continues with problem solving. TQM uses six problem-solving steps.

1. Identify the problem,
2. Analyze the root cause,
3. Identify the solution,
4. Test the solution,

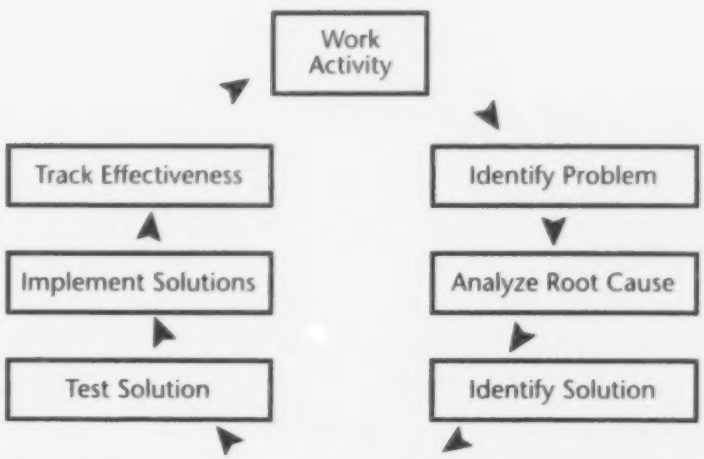
5. Implement the solution, and
6. Track the solution's effectiveness

As seen in the previous section and in the list below, the TQM tools described earlier may be applied to organizational problem solving:

Flow Chart	Identify steps in a process
Cause-and-Effect Diagram	Identify causes and problems
Pareto Chart	Identify "vital few" problems
Scatter Diagram	Determine if relationship exists
Histogram	Identify variation and patterns
Run Chart	Identify trends over time
Control Chart	Determine if process is in control

The circular model shown in Figure 6.10 suggests the ongoing nature of solving problems. Sometimes as problems are solved, new problems are created. Old solutions can become new problems. Solving problems is critical to the success of TQM, especially in finding process improvement solutions, rather than the "quick fix."

Figure 6.10
The Problem-Solving Cycle



Note that in the third step, Identify Solution, the *solution is chosen from among alternatives.* And the last step, Track Effectiveness, an evaluation and monitoring step, is critical to the success of the problem solving effort and completes the circle.

Consider this...

Old paradigm: Adjust the target; change the process.

New paradigm: Reduce variation; stabilize the process.

Problem-Solving Tools

Following are descriptions of additional problem-solving tools that have been developed or modified in recent years. These tools have proved to be quite helpful for team problem solving.

The **Six-Word Diagram** is a technique that ensures all aspects of a problem are addressed by asking: What? How? Why? Where? When? Who? The Six-Word Diagram is a simple technique used to make sure all aspects of a problem have been covered before a decision is reached.[4] Asking and answering each question should ensure that the research, diagramming, identification, and analysis of the problem are complete. Then solutions can be generated, tested, and implemented.

Brainstorming is a technique for generating a large number of ideas in a noncritical environment; this technique encourages team work and creativity through the following guidelines:

- Clarify the topic,
- Never criticize or judge ideas,
- Record every idea that is mentioned, and
- Work quickly.

Brainstorming helps teams to develop synergy and creative alternatives to problems when used effectively.[5] After the brainstorming of ideas is complete, the team can complete these tasks:

- Clarify any unclear ideas,
- Establish criteria,
- Narrow down the list—eliminate and combine ideas,
- Advocate and explore pros and cons of each ideas,
- Discuss and research practicality and cost,

- Narrow down again—choose three to five ideas that would work,
- Select one idea as a solution, and
- Use the remaining ideas for Plan B, if needed.

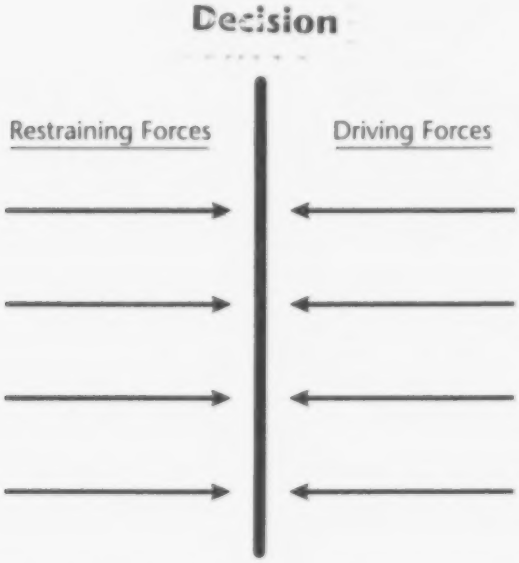
The **Nominal Group Technique** is a more structured variation of brainstorming.[6] This technique works best in groups of 15 people or less and can produce a great number of ideas in a short time. A nominal group can focus on problems—not people—to open lines of communication, to ensure participation, and to tolerate conflicting ideas. This method is most appropriate in new groups, teams containing a majority of reflective thinkers, or in situations where anonymity or confidentiality of ideas is important, because this method also helps to build consensus and commitment to final results. This technique involves seven steps:

1. Present the issue. Give instructions.
2. Generate ideas individually, without discussion.
3. Gather ideas in a round-robin, one at a time, and record on flipchart.
4. Clarify ideas, eliminate duplicates, and combine similarities. Limit discussion to brief explanations or analysis of an item, and brief agreement or disagreement statements. Focus on meaning of ideas, not arguing points.
5. Set priorities individually.
6. Tabulate votes (through value- or multi-voting).
7. Develop an action plan.

The **Force Field Analysis** was developed several decades ago by Kurt Lewin, a noted social psychologist.[7] This tool helps to analyze the forces that restrain or deter a decision from occurring, and the forces that drive or help a decision to be implemented (see Figure 6.11). Force Field Analysis is helpful in strategizing for effective implementation of decisions that have been made. It is also useful for testing a decision to see if it will work in a given organization, situation, or group.

Figure 6.11
Force Field Analysis

From L. Yount, *Total Quality Management: Using the Tools to Get Started* (Arlington, VA: Lynnette Yount Associates, 1994), p. 57, with permission of author.



- State the problem as it is now—its *present state*—and enter this at the bottom left of the chart.
- Figure out what improvement in the situation you want—your *desired future state*—and enter this on the bottom right of the chart.
- Brainstorm for *driving forces*—factors pushing toward your desired future state—and enter them on the left side of the chart.
- Brainstorm for *restraining forces*—factors that prevent you from moving toward your desired state—and enter them on the right side of the chart.
- Use the *force field chart* to help you discuss which are the prime factors that prevent you from reaching your desired state and what you can do about them.
- Similarly, find the most effective driving forces and capitalize on them.

Does Team Problem Solving Work?

The shift to team problem solving for child welfare agencies, like any other organization, takes time, practice, and patience, but the results that have emerged are encouraging. The following example is illustrative of how an agency's commitment to child self-help treatment wherever feasible can make a difference.

> A resident child who presented with severe behavior problems was discharged from the center but remained on the site grounds. While the seriousness of the behavior problems lessened, they were still evident to the family and site team. The site team members continued their involvement with the child, and through observation and problem solving, they discovered the boy's latent basketball-playing skills. The team encouraged the boy to develop his skills and encouraged his school and family to provide incentives. The approach worked. The boy's self-confidence grew and his grades in school improved—a B average.[8] In the past, the individual case worker would have been responsible for initiating ideas to help correct bad behavior and provide appropriate punishment or incentives. The likelihood of this outcome—given the amount of observation and problem solving a team provides—is greater than with the one-to-one approach.

In another example, employees have had success adding brainstorming steps to their team problem solving approach.

> A clinical group identified a high incidence of kids going Absent without Leave (AWOL) from the residential treatment centers (RTCs). Rather than delegating the problem up to their program managers, the group made their own observations of what was occurring, conducted interviews with kids from the RTCs, and then held a brainstorming session on their own. The changes they made to handling incidents that could lead to kids going AWOL resulted in a significant decrease in unaccounted for incidents the following year. The direct improvements were attributed to the group's interactive effort and led to the development of practice guidelines now in place.[9]

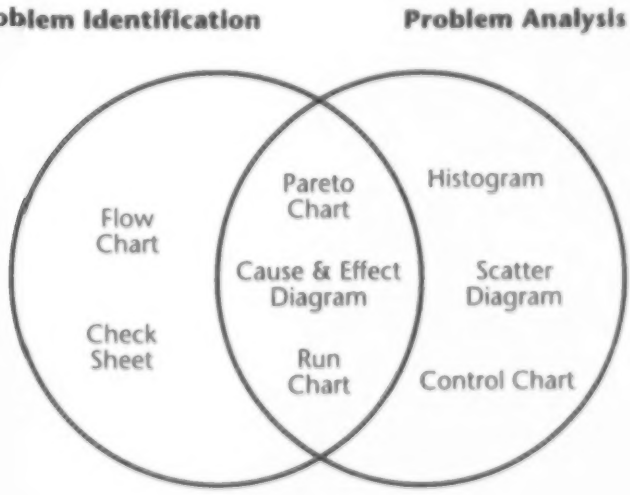
Summary

Work Process Analysis is the key to improving productivity efficiency, customer service, employee satisfaction, and overall quality. This method is a real behavioral solution to improving these elements, rather than trying to get more work out of employees with no plan of how to do it.

Basic quality tools and problem solving tools are essential for teams to employ in diagnosing problems and selecting among alternative solutions. A reference chart for the eight basic quality tools identified in this chapter is presented in Figure 6.12.

Figure 6.12
Use of Basic Tools

From L. Yount, *TQM Tools and Techniques* (Arlington, VA: Lynnette Yount Associates, 1995), p. 62, with permission of author.



Exercise 6.1

1. List examples of your typical work processes.

2. Identify two or more substeps for each work process.

3. Identify which system each process falls under.

Exercise 6.2
Analyze a Work Process

Use TQM tools to help you analyze the following problem work process.

1. Work Flow Analysis using a Flow Chart
Task: Diagram below the process for handling customer complaints currently used in your agency. Use an oval for start and end points, boxes for process activities, and diamonds for decision points. Use arrows to show the flow. (*Suggestion*: List the steps first, order them next, and then form them into a diagram. Identify the main steps; do not get bogged down in minute details.)

2. Cause and Effect Diagram
Task: Diagram below the possible causes for customer complaints to your agency doubling over the past year. (*Suggestion*: The 'Effect' box

states the problem, e.g., "Customer complaints up 100%." Add your own categories in the 'Cause' boxes if the examples on page 73 do not meet your need.)

3. Pareto Chart

Task: Use a Pareto Chart to determine which of the following likely causes of an increase in customer complaints to your agency should be addressed by a Quality Improvement Team.

Your "data" include the following:

(a) Phone calls not returned promptly [29 complaints filed];

(b) Received incomplete or inaccurate information [10 complaints];

(c) Phone call response was rude or insensitive to customer's concern [43 complaints];

(d) Agency did not follow-up with customer as promised [11 complaints]; and

(e) Information received was out-of-date [20 complaints].

4. How might these TQM tools be useful in your work?

Exercise 6.3

Identify which TQM tools would be helpful at the various stages of the Problem-Solving Cycle.
Work Activity:

Identify Problem:

Analyze Root Cause:

Test Solution:

Track Effectiveness:

Possible Answers:

Work Activity: Check Sheet, surveys, assessments, etc.

Identify Problem: Flow Chart, Cause-and-Effect Diagram, Pareto Chart, Scatter Diagram, Run Chart

Analyze Root Cause: Cause-and-Effect Diagram, Pareto Chart, Histogram, Run Chart, Control Chart

Test Solution: Histogram, Run Chart, Control Chart

Track Effectiveness: Histogram, Run Chart, Control Chart

Notes

1. *The Random House dictionary of the English language*, Second Edition. Unabridged. (New York: Random House, 1987), p. 1542.
2. K. Ishikawa, *Guide to quality control* (New York: UNIPUB, 1985).
3. J. M. Juran, *Juran on planning for quality* (New York: Macmillan, 1988).
4. From nonreferenced material distributed by the Federal Quality Institute, Office of Personnel Management, to all Federal agencies, 1990–1995.
5. Federal Quality Institute.
6. Federal Quality Institute.
7. G. Weiss Lewin, ed. *Resolving social conflicts: Selected papers on group dynamics by Kurt Lewin.* (London: Souvenier Press, 1973).
8. Based on personal discussions with Senior Management staff of Woodbourne Center, Inc., May 7, 1997.
9. Woodbourne Center, May 7, 1997.

7

How TQM Is Accomplished

This chapter covers the remaining management practices—commitment to training and recognition and quality assurance—and addresses implementation strategies and tools for organizations to use in initiating TQM programs. This chapter concludes with two resources to help your agency assess its current quality progress.

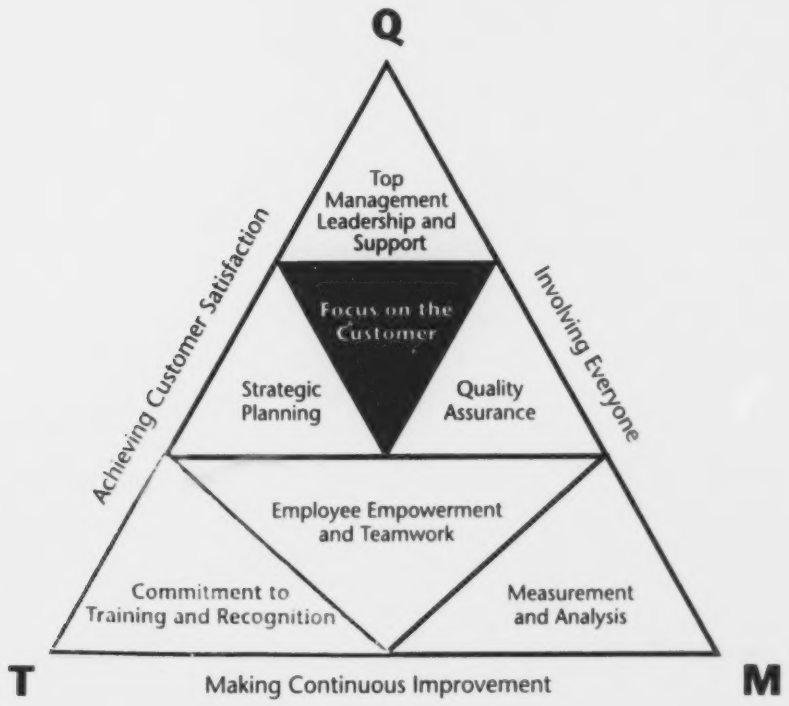
Commitment to Training and Recognition

Training is essential to the success of TQM (see Figure 7.1). Without proper training, how can employees be expected to carry out their roles and responsibilities? Public service agencies are already committed to training. Technical training is now an imperative in the child welfare industry as everyone, especially child care workers, must continually increase their skills and competencies to meet the changes in the nature of child treatment and care.

For example, an agency might institute its own Leadership Academy to meet this ongoing need. The Academy would develop its own training curriculum and provide internal and/or external training staff for the organization's short-, medium-, and long-term leadership needs. The Academy may be housed in the same or nearby facilities and represented on critical decision-making teams or groups that monitor and address organizational performance. Numerous organizations committed to continuous improvement and training, such as General Electric, Ford Motor Company, and the U.S. General Services Administration, provide their own "academy" or internal leadership training organization.

Figure 7.1
TQM Practice #6: Commitment to Training and Recognition

Adapted from the Federal Quality Institute model.



Consider this ...

Old paradigm: Establish a consistent, good product/service, and the rest will take care of itself.

TQM paradigm: Pursue excellence in product and service; pay attention to training, support, recognition, rewards, and commitment.

To ensure success for implementing TQM, everyone in the organization must be trained in the service, measurement, and team areas too. Individuals are encouraged to pursue their own training so they will be ready when their organizations proceed with implementation. Listed below are types of TQM training:

- Awareness,
- Leadership roles,
- Implementation,
- Quality improvement process,
- Statistical Process Control (SPC),
- Customer service,
- Facilitation skills, and
- Team building—group dynamics, Quality Team roles, diversity.

Reward and Recognition

Most people know the importance of being adequately recognized and the effect recognition has on performance and self-esteem. The important point for TQM purposes is that reward and recognition systems must be in alignment with TQM goals.

Public service agencies typically experience morale problems, due to the relatively low pay the field provides, and an increasing number of child care workers now hold second jobs. Low incentive can translate into unconscious work—work performed without thinking, which results in adequate service becoming "good enough." Management is responsible for addressing this dilemma. A good salary is an important incentive, as are opportunities for training, continuing education, and, if agencies are committed to quality, other valuable investments that management can find to support and develop the professionalism of their employees.

Recognition systems that do not include continuous feedback to employees for good work, whether by memo or personal "thank-you's," are missing the most powerful positive motivational resource available—at no cost beyond a moment or two of time. An agency whose management has come to recognize effective communication (especially reinforcement for positive treatment and care outcomes) and employees who are well-informed in the areas that affect them, has the greatest possible tools for building morale.

Massive change will occur as a result of implementing TQM. Recognition of behaviors and efforts in the TQM direction is essential if those changes are to take place. We must reward honest effort, not only positive results. We must honor the "process whistle-blowers" and those

who take risks to please the customers. Employees cannot be punished for surfacing problems, giving direct feedback, etc.

We must also find new ways of providing recognition; moving from the old paradigm of rewarding only individuals to rewarding teams as well. This is a challenge to all TQM-practicing organizations. Keep in mind the following items:

- The things that get rewarded get done,
- The things that do not get rewarded generally do not get done,
- Tie rewards and recognition to quality improvement behaviors, and
- If you are not getting the results you want, ask, "What's being rewarded?"

Consider this story: a Japanese automobile worker finds a flaw, reaches overhead to pull a cord, sounds a whistle, and stops the assembly line. A manager immediately comes forward and bows and thanks the employee for finding the flaw. What would happen at a U.S. automobile manufacturer if an employee stopped the line?

Quality Assurance

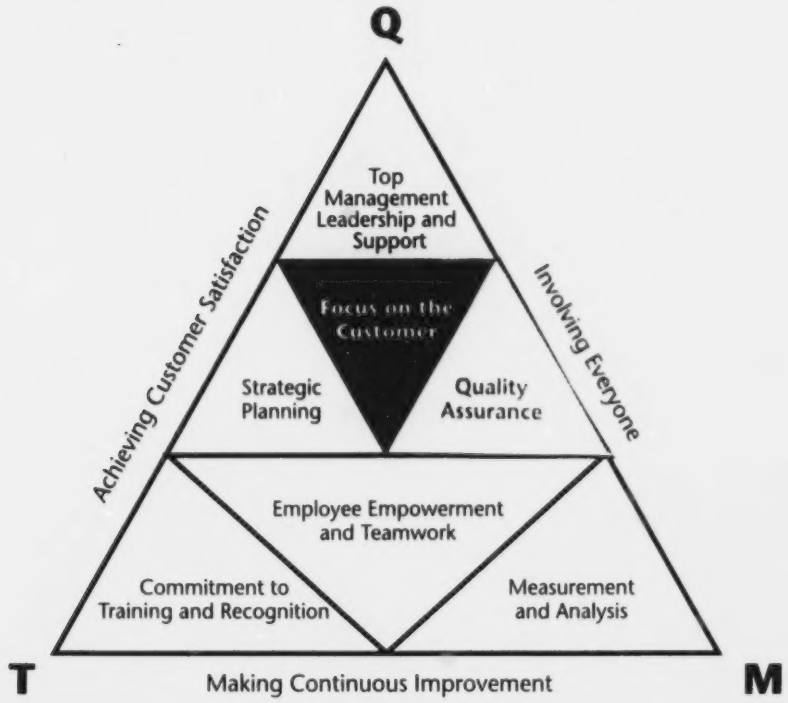
Once quality mechanisms have been established and improvements have been made, how do we make sure they will continue? Since quality improvement is a never-ending process, how can we ensure we are continuing to meet our customers' needs? Systems for addressing these concerns are called *quality assurance*. Quality assurance applies the major concepts we have been discussing in this book to guarantee the organization's services and products meet all customer requirements. (See Figure 7.2).

Quality assurance ensures that the quality standards that have been set by the organization, based on customer requirements, are consistently met. Quality assurance occurs throughout the process of development of services or product, not at the end of the process.

How can quality be assured? Refer to the Quality Pencil Exercise in Chapter 1. How do you assure quality in pencils? Perhaps build in an inspection system? Or examine processes, check supplies, and build in quality as you go? In TQM, the best approach is to build in quality at every step of every work process. The other approaches are inadequate to assure sustained quality outputs.

Figure 7.2
TQM Practice #7: Quality Assurance

Adapted from the Federal Quality Institute model.



For example, to test the effectiveness of inspection, turn to page 96 and count all the "f" letters. You have been hired to be an inspector, as you are highly qualified (you know how to read, and you know what the letter "f" looks like). "F" and "f" stand for Flaw, and every time one slips through the system, it costs the agency $1,000. You are to count through the page only once; you are too busy to do rework.

You may find between 35 and 37 "F's". So how effective is inspecting? The "trick" to this exercise is that most people will see "F's" at the beginning or in the middle of words, but will miss the "F's" at the end of words, particularly the word "of." Inspection alone, therefore, is insufficient to assure quality products and services. What, then, constitutes a systematic approach to quality for an organization?

Quality Assurance System

A quality assurance (QA) system puts the responsibility for quality on everyone, in all aspects of their work—management, supervisors, and employees. QA is a coordinated effort that involves not only production or service work groups, but internal support groups, which means that everyone measures and analyzes what has occurred and anticipates what may occur. This process becomes a key part of everyone's incentive program and a way to communicate to coworkers and customers about how things are done, how the organization is doing, and what improvement are planned and underway. When developing a *Quality Assurance System*, organizations should cover the checkpoints suggested by D. Scott Sink, Director of the Virginia Tech-based Center for Organizational Performance and a frequent writer on quality.[1]

You can again use the Quality Pencil Exercise from Chapter 1 (Exercise 1.1) as an illustration for working through Sink's "5-Quality Checkpoint Model," which is described below. (Supplier specifications would include standards of wood, paint, lead, rubber erasers, metal bands to secure erasers, etc.)

1. **Develop and maintain standards, specifications, and requirements.** Includes suppliers and customers, both internal and external. The product cannot be better than the supplies that are used to produce it. Maintaining specifications ensures the end product meets the final requirements.

2. **Establish incoming quality assurance.** Customers have an obligation as well to contribute to quality. Customers need to communicate with you that what they wanted, needed, or requested was done on time according to their requirements. This implies developing relationships with customers where feedback is the norm.

3. **Practice in-process quality management and assurance.** This ensures that the processes themselves are doing what they are designed to do efficiently and effectively. They are building in quality at every step of the way. Quality Improvement Project (QIP) teams and employees are empowered with responsibility for taking action and building in quality at all times, and they employ SPC tools to notice trends, inconsistencies, variances, and problems.

4. **Institute outgoing quality assurance.** This is the last checkpoint to ensure that the systems are creating products

and services that meet customer requirements and specifications; the point of service or final production worker ensures total quality.

5. **Practice proactive assurance.** This means commitment to continuous improvement and constant vigilance for ways to exceed customer requirements. This involves the "passion" for excellent customer service and includes developing excellent working relationships with suppliers and customers.

Reprinted with permission of Engineering & Management Press, from D. Scott Sink, *Planning Measurement in Your Organizations of the Future* (Norcross, GA: 1989), p. 179.

The Relative Costs of Quality Assurance

Chapter 5 introduced the concept of relative costs. This is a slightly different way of looking at quality costs. One estimate says that quality costs of manufacturing companies are approximately 25% of their total revenues. The estimate for service organizations is 30% or higher. When TQM is practiced, these figures can be drastically reduced, saving millions of dollars per year to American organizations.[2]

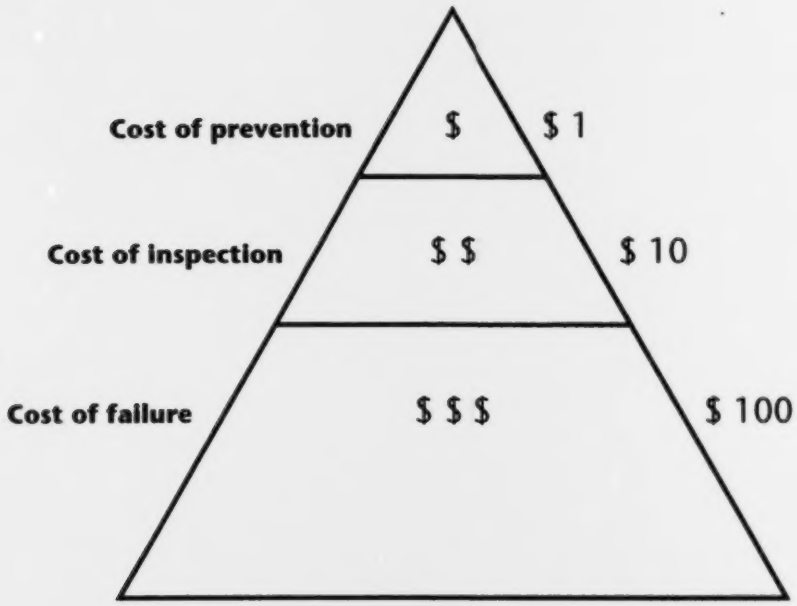
Figure 7.3 displays the "1–10–100 Rule."[3] For every dollar that your organization might have spent on prevention, it will spend $10 to inspect, discover, and correct mistakes. If mistakes are not discovered, your organization will pay about $100 to address the problem after the customer has discovered it. The result is paying 100 times what you might have been paid initially through preventing quality problems. This supports the idea of Quality Assurance from start to finish.

Corrective Action

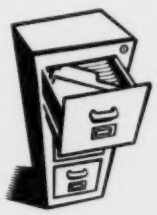
Finally, your Quality Assurance system must provide for the *Corrective Action Function.*[4] There needs to be some entity (be that an individual or an oversight group, e.g., Management Team, Quality Council, Quality Management Board (QMB), Quality Steering Committee) that has the authority to intervene when necessary. Systemic problems within organizations tend to follow the 80/20 Rule. (See Figure 7.4.) Only 20% of the problems with systems occur within divisions or within the processes themselves. Eighty percent occur *between* divisions, or in the pass-off or transfer of work between divisions. A division itself cannot solve this kind of problem—it is out of their sphere of control. A higher body must be in operation to provide oversight in this situation.

Figure 7.3
The Relative Costs of Quality Assurance

Adapted from Federal Quality Institute material.



Corrective Action teams are usually cross-functional and consist of five or six high-level individuals. This group provides top level management with a bird's eye view of what is going on within the organization. Problems that cannot be addressed on a unit or division level are referred to this body. Sometimes all problems are given to a Management Team, Quality Council, or QMB that then assigns them to appropriate decision makers.



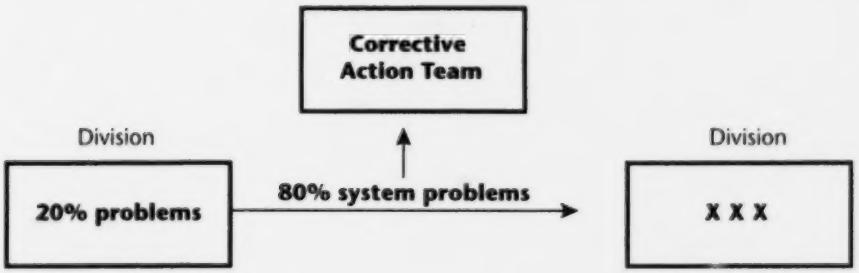
Listed below are **key points** to remember about Quality Assurance:

- The customer defines requirements,
- Everyone is accountable,
- Problems are not passed through the process to check points,

- Management believes and trusts in employee empowerment,
- Focus on prevention, and
- Quality is built in at every point.

Figure 7.4
Corrective Action

From L. Yount, *Total Quality Management: An Overview* (Arlington, VA: Lynnette Yount Associates, 1993), p. 93, with permission of author.



Organizational Change

TQM is not a fad or a phase, but rather a long, integrated process that occurs over many years and never ends. This requires a long-term commitment that begins with top management and spreads throughout the organization. TQM is a philosophy that will dramatically change organizations, rethinking every aspect of the "way we've always done business."

The time has arrived to change old paradigms. Three things help change to occur.

1. **Dissatisfaction with the status quo**. How many Americans are thrilled with their jobs?
2. **Seeing alternatives**. How can we do things better?
3. **Believing change is possible**. Can we envision and create a better way?

Long-term commitment to quality requires change in an organization's culture. Culture is comprised of overt and covert behaviors, practices, policies, and beliefs. The existing culture probably took a long time to develop in the first place, and because the elements that comprise organization culture are usually things that we value

highly, developing a quality culture takes a long time. An organization's culture becomes its predominant paradigm. Organizational culture includes a set of beliefs, values, attitudes, management philosophies and practices, norms, employee work habits, assumptions about work and people, and recognition and reward systems. One of the truly exciting aspects of TQM is that its implementation changes the culture of organizations. Following is a comparison of what a quality organizational culture is and what it is not:

What a Quality Culture Is	*What a Quality Culture Is Not*
Listening to customers to determine their requirements	Assuming you know your customers' requirements
Identifying costs of quality and focusing on prevention	Overlooking the hidden costs of poor quality
Doing the right thing right the first time	Doing it over to make it right
Continuing process improvement	One-time fix
Taking ownership at all levels of the organization	Assigning responsibility for quality to one department
Demonstrating executive leadership and commitment	Assigning responsibility for quality to others

The challenge is to change our agency cultures to environments that are flexible, creative, open to change, where people work together, where pride of workmanship is reinstated, and where people give their best. Attitudes and behaviors must change to accomplish this.

One of the major changes in the culture will be to participative management, rather than autocratic or hierarchical management. Many people are now referring to this as "flattening" the organization, rather than maintaining the tall, top-down structures of old.

The toughest challenges for child welfare agencies may be their ability to move from a culture of crisis management to one of follow-through on plans and priorities; from holding to the old comfortable way of doing "my" part of the job to taking ownership for outcomes at all levels of the organization. The basic issue of how child welfare will be practiced in the future is under debate. Is the agency's role one of keeping children out of trouble or providing long-lasting behavioral change? The commitment and skill needed to accomplish the latter requires a quality culture to bring the needed organizational capacity into reality.

Summary

Much is required of everyone to make TQM truly successful in an organization. Organizations must adhere to all of the seven principles, including training and recognition. Everyone, especially top management, must make a strong commitment. Management is responsible for planning, supporting, creating, and responding to needs and issues that arise during the process of accomplishing TQM. Management is also responsible for ensuring quality goods and services for the customers. The implementation of Total Quality Management takes many years to achieve, and then it is an ongoing process that continues the quest for quality.

At the end of this chapter, we offer two resources for helping your agency assess its current quality progress. Use these tools to gain insight into your agency's strengths and weaknesses around TQM principles and practices. That insight will be helpful in developing your organization's initial TQM plan of action.

The instruments were chosen because of the authors and editor's experience with them as useful assessment tools they can recommend to other agencies. The first assessment instrument is a self-audit designed to help your organization know and follow national criteria established by the Federal government. Many organizations want to compare and contrast their efforts to other organizations around the country. This instrument provides a basic introduction to the Federal approach. It is not sufficiently detailed in scope to enable an organization to pinpoint problems and take action. Further assessment and analysis are needed.

The second instrument involves a more in-depth assessment that enables organizations to assess and compare their current situation to a quality norm in 10 different areas. Each area's topics were selected by the authors at the University of Maryland and may or may not be useful for comparison to other organizations that use a different set of criteria.

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FQI Quality Improvement Prototypes

Reprinted from Federal Quality Institute, *FQI Quality Improvement Prototypes* (published annually by FQI/OPM for distribution throughout the Federal system, 1991-1995, as samples to help agencies develop their own assessment tools).

Using the categories for the Federal Quality Institute Quality Improvement Prototypes and President's Award, rate your organization's progress. Use a scale of 1 to 10, 10 being the highest score.

Quality Leadership _____

1. Have the leaders and decision makers in your organization been adequately trained in TQM knowledge and skills?
2. Do these leaders practice what they preach; i.e., promoting quality and demonstrating TQM practices?

Quality Measurement and Analysis _____

3. Are mechanisms in place which measure and track your office's progress?
4. Are these measurements monitored, discussed, and assessed?

Quality Improvement Planning _____

5. Are quality problems identified and discussed?
6. Are quality improvement plans developed to improve performance?

Employee Involvement _____

7. Are employees given current and accurate information needed to do their jobs and improve their performance?
8. Are employees consulted and included in decision making on issues that directly affect them?

Employee Training and Recognition _____

9. Have employees been trained in TQM awareness, knowledge, and skills?
10. Are all employees recognized for their improvement, contributions, and special achievements? Are teams recognized for their contributions?

Quality Assurance _____

11. Does your office meet its customer requirements the majority of the time?
12. Are there mechanisms in place to monitor the consistent delivery of quality?

Customer Focus _____

13. Is there a formalized method of obtaining customer requirements?
14. Is there a formalized method of obtaining customer feedback?

Results of Quality Improvement Efforts _____

15. Are there documented results of savings in time or money due to quality improvement efforts?
16. Has customer satisfaction increased due to your office's quality efforts?

Organizational Assessment Self-Audit

Reprinted with permission of Maryland Center for Quality and Productivity, Maryland Business School, University of Maryland, College Park, from "Organizational Assessment Self-Audit," in J. Hodge-Williams, J. Anderson, and J. F. Spratley, *Getting Started with Quality Centered/Team Focused Management* (unpublished manuscript), pp. 16-19.

Organizational Assessment Self-Audit

Purpose: Past research and consulting experience at the Maryland Center for Quality and Productivity, University of Maryland, College Park, has identified 10 dimensions as the key ingredients for sustaining organizational quality and productivity improvement. The data show that the higher an organization scores on these 10 variables, the greater the likelihood for quality efforts to be supported and produce successful results. Use this instrument to give you an assessment of how well your organization is doing.

Instructions: Please rate your organization on each of the 10 key dimensions listed below by circling the appropriate number on the 1 to 7 scale that follows the dimension description. Explanations are included below each of the numbered scales to give you a clearer understanding of the dimension being rated. *Please circle one and only one number for each dimension and do not leave any question blank.* Transfer these responses to the score sheet located at the end of this self-audit. A separate sheet is also provided for any comments you may wish to make regarding this self-audit.

1. Awareness of the Challenge

The extent to which members of the organization are aware of the various competitive, economic, and budgetary challenges faced by the company.

1	2	3	4	5	6	7
Little evidence that members of the organization are aware of challenges.		Top management is aware of the challenges, but few others are.			People at all levels are aware of the challenges.	

2. Vision for the Future

The degree to which top management has developed and communicated a clear direction for the organization (i.e., expansion/reduction of the

work force or facilities, organizational changes, introduction/elimination of products/ services, etc.) and the extent to which other members understand and embrace this vision.

1	2	3	4	5	6	7
Little evidence that the organization has a vision for the future.		Some evidence of a top management vision but little understanding of that vision by others in the organization.			People at all levels are aware of and support the company's plans and vision for the future.	

3. *Top Management Leadership*

The extent to which top management informs employees about quality/ productivity issues, and supports the quality/productivity efforts throughout all levels of the organization.

1	2	3	4	5	6	7
There is rarely any mention of quality or productivity issues.		Top management talks about quality/ productivity issues, but few lasting changes are implemented.			Consistent, visible top management support for quality and productivity efforts.	

4. *Innovation Is Encouraged*

The extent to which the company actively encourages employees to take risks and find creative solutions to business problems rather than "playing it safe."

1	2	3	4	5	6	7
Most managers want to "play it safe" and avoid new approaches to business experience.		Risk-taking is tolerated but not promoted. Failures are not used as a learning experience.			Risk-taking is encouraged by management and failure is viewed as a learning problems.	

5. *Broad Employee Involvement*

The extent to which the organization provides structured mechanisms for employee involvement in decision making (i.e., problem-solving teams, autonomous work groups, task forces, etc.)

1	2	3	4	5	6	7
There are no structured mechanisms for employee involvement in decision making.		The company has various employee involvement programs established, but less than half of the work force participates in them.		There are effective structured mechanisms for employee involvement which reach over half of the work force.		

6. *Structure Fits Strategy*

The extent to which information and resources are allowed to flow throughout the company to provide an atmosphere that is flexible to change, perpetuates a team-culture, and supports the organization's goals, objectives, and "vision."

1	2	3	4	5	6	7
Information and resources do not flow throughout the organization, rather they remain in the hands of top management.		Information and resources flow to few members of the organization, and the flow is hindered by the many management levels.			Everyone in the company has the information and resources necessary to perform their job and support the company's vision.	

7. *Appropriate Technology*

The extent to which the organization is able to identify and is willing to invest in the appropriate equipment and technology so that the company can compete effectively in the marketplace.

1	2	3	4	5	6	7
Investment in production/office technology is evaluated only on short-term cost.		Long-term considerations sometimes outweigh short-term costs in technology decisions. (Ideas for new technology, however, rarely come from non-management employees.)		Long-term considerations routinely outweigh short-term costs in basis of technology decisions. Ideas for new technology often originate with non-management employees.		

8. *Development of People*

The importance placed on the development of individuals within the organization and the existence of organizational mechanisms (i.e., training, management accountability structure, promotion and reward system, etc.) to support human resource development.

1	2	3	4	5	6	7
There is little explicit commitment to employee development and few organizational mechanisms to support it.		Employee development opportunities exist, but organizational mechanisms do not effectively encourage or reward this development.			Managers are held accountable for the development of their people. Human resource development is considered an important company policy.	

9. *Focus on Performance*

The extent to which the organization's performance expectations translate into clear measurement and feedback systems that focus on actual performance rather than on cost/budget considerations.

1	2	3	4	5	6	7
Performance expectations are unclear and there is little apparent relationship between the expectations and the performance measures.		Performance expectations are reasonably clear, but measurement and feedback systems focus on cost/budget rather than on actual performance.		Performance expectations are clear and measurement systems permit employees to gauge their own performance.		

10. A Way of Life

The extent to which continuous improvement is viewed as a "way of life" in the organization, and is consistently encouraged and rewarded.

1	2	3	4	5	6	7
Continuous improvement is neither encouraged nor rewarded. Quality and productivity are not a "way of life" in the organization.		Continuous improvement is inconsistently encouraged and rewarded. Not all employees view quality and productivity as a "way of life" in the organization.			Continuous improvement is consistently encouraged and rewarded. Most employees view quality and productivity as a "way of life" in the organization.	

Score Sheet

Company Name:_____ Date: _____

Please review the previous pages and your answers. Put the numbers in the space provided below. A space is provided on the back of this sheet for your comments. You may keep the previous pages. Thank you again for your participation.

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

You are encouraged to provide any amplifying comments about your responses to the self-audit in the space provided. Use these comments in your discussion.

Exercise 7.1

Referring to Figure 7.4, identify the positive attributes of a Quality Culture in your agency.

What attributes may be perceived as keeping your agency from achieving quality?

Exercise 7.2

1. If you have been included in a participative management action (Quality Circles, group decision making, shared leadership on the job, etc.) what was your experience of it: a success or failure? Offer a few reasons for your conclusion.

Note: For many, if the human concerns were not adequately addressed along with the technical concerns, they will express dissatisfaction with the participative management process. An extremely important point to make at this time is that TQM principles can fail if sensitivity to political and human concerns is neglected. For most people, change is frightening. Shifting from old paradigms to new ones can be terrifying. We must deal truthfully and realistically with human needs as we endeavor in TQM.

2. Anticipate what would be your agency's reaction if these activities were carried out:

   a) You go back and use the TQM tools but no one else knows about them.

   b) You attempt to teach your boss these tools.

   c) You attempt to use TQM principles in your work.

   d) You and your work group improve your productivity and your counterpart group does not.

   e) Your work group rebels at the idea of building in quality and eliminating their inspection roles.

Note: Planning, forethought, and sensitivity are required to manage these issues effectively. Support will become very important as people go through the coming changes. Communication will be essential.

Notes

1. D. Scott Sink. *Planning measurement in your organization of the future.* (Norcross, GA: Engineering& Management Press, 1989), p. 179.
2. From nonreferenced material distributed by the Federal Quality Institute, Office of Personnel Management, to all Federal agencies, 1990-1995.
3. Federal Quality Institute.
4. Federal Quality Institute.

8

Steps in the TQM Process

This final chapter looks at different TQM implementation models. Organizations already applying TQM practices implement them in different ways. One program advocates taking one year for the first step, calling it Creating Quality Culture. Other organizations begin the process at the top level—learn the tools and techniques, use them, and then proceed in phases to implement TQM at the next highest level. Figure 8.1 illustrates the necessary steps to TQM success.

Steps to TQM Success

Ford Motor Company is one of the most notable TQM success stories in American business. In 1980 they hired Deming, who helped to turn the organization into the most successful car company in the United States *and* enabled Ford to successfully compete with the Japanese. (Ford and Honda continually swap first place in the moderately priced family car category with Taurus and Accord models, respectively.) This is a major accomplishment considering most American cars in the 1970s were considered "junk." It has forced the quality of all American cars to improve drastically.*

American automobile companies are now competing against one another to provide the best service. Several companies now offer 24-hour breakdown protection (onsite services for your car anywhere, anytime it breaks down) in the luxury car class. In how many years will this service be offered on all cars?

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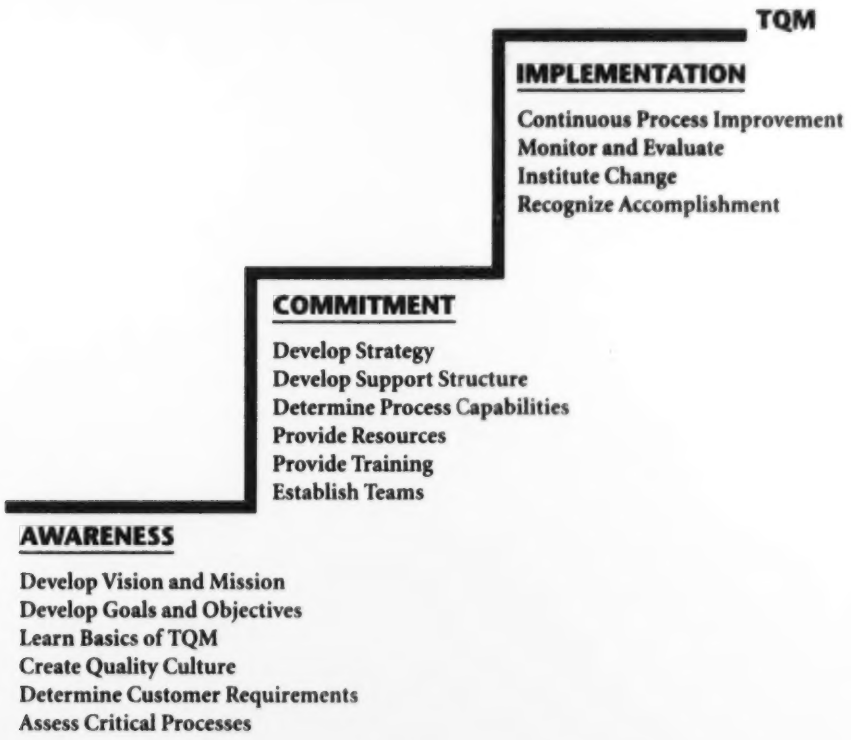
* For further reading see P. J. Ingrassia, & J. D. White, *Comeback: The Fall and Rise of the American Automobile Industry* (New York: Simon & Schuster, 1994); and T. L. Weekley, *United We Stand: The Unprecedented Story of the GM-UAW Quality Partnership* (New York: McGraw-Hill, 1996).

Figure 8.1
Steps in the TQM Process

From L. Yount, *Total Quality Management: An Overview* (Arlington, VA: Lynnette Yount Associates, 1994), p. 100, with permission of author.



The success stories in behavioral health care are emerging as agencies work to identify and implement best known practices in treatment and other processes. Following are two examples of "success stories"[1] in behavioral health care.

Agency X is a large, private, not-for-profit, multiprogram, multisite treatment setting, serving children and adults in the eastern United States. It is a fully licensed, JCAHO-accredited program, operating with a budget of more than $15 million and a staff of 300. Those served are largely inner-city black and Hispanic children, ages 7-17, and their families. The main residential program is in a rural, "farm" setting with many adjunctive programs serving other populations in surrounding areas both within and without the state. Although all of the traditional

therapeutic modalities are provided, this agency makes extensive use of animal-facilitated therapy.

Agency Y is a small, private, not-for-profit 24-bed residential treatment setting for preadolescent boys. It is located in the western United States. The children served by this program come from throughout the entire country. It is a fully licensed, JCAHO-accredited program that enjoys the distinction of having received this accreditation "with commendation" the last three times in a row. All traditional treatment modalities are utilized. The current per-diem is under $200.

Strategies for Implementation[2]

Regardless of the approach to implementation, the goal is to form a *critical mass* that will positively affect the rest of the organization. (Critical mass is the sufficient agreement or conformance to an idea or approach to swing support decidedly from the former idea or action to the new way of thinking or acting as an organization.) Any of the strategies—top-down, spike, pocket—can be effective; it depends on the individual organization (see Figure 8.2). Where to begin implementation is a management decision. People often begin to practice certain aspects of TQM within their own offices, at their own direction, once they are trained.

Benchmarking

Most often, when organizations start to improve their way of operating, they look for the excellence among their own kind—those they know by reputation and experience. At best, this approach only allows an organization to "catch-up," not to reach the benchmark for that work process.

The health care industry is known for its excellent processes in records management for organizations and is where other organizations look when they want a model as a basis to improve their own records management system. The health care industry thus sets the standard, or *benchmark*, in records management for nonprofit organizations.

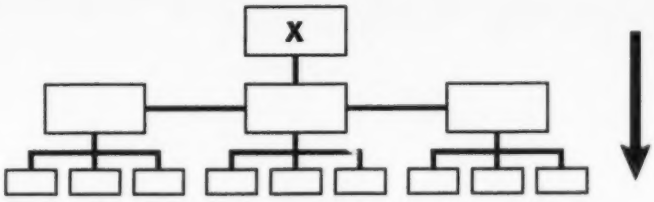
Benchmarking is the process of actively seeking the best practices within your own or other organizations for comparison to continuously improve your operations and services.

The idea of benchmarking is to find and focus on exemplary system and work process leaders wherever they are—the best practices that satisfy customers. There are five steps to Competitive Benchmarking.[3]

Figure 8.2
Strategies for Implementation

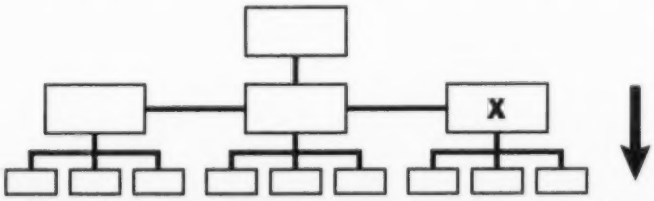
From L. Yount, *Total Quality Management: An Overview* (Arlington, VA: Lynnette Yount Associates, 1994), p. 102, with permission of author.

TOP-DOWN



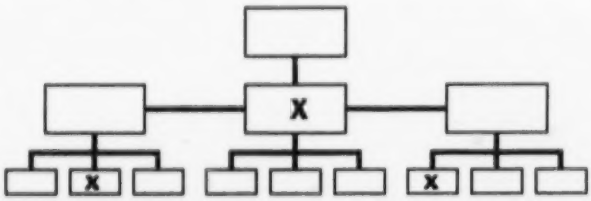
1. **Top-Down or Cascade**—Implementation begins with top management and is "cascaded" down through the levels.

SPIKE



2. **Spike or Slice**—One particlular department or division is selected, and TQM is implemented throughout that division.

POCKET



3. **Pocket**—Different places, or pockets, in the organization are chosen for pilot efforts either because of readiness or suitability.

1. Identify
   - The function or activity to be studied,
   - The benchmarking subject, and
   - The information to be gathered.
2. Gather Data
   - Contact benchmark "world-class" subject,
   - Make onsite visit, and
   - Gather data.

3. **Analyze**
   - Strengths/capabilities of the benchmarking subject,
   - Your organization's record/data,
   - Your performance compared to benchmark strengths, and
   - Gaps between goals and outcomes.
4. **Practice improvement planning**
   - Establish improvement goals;
   - Develop plan to change, correct, improve function; and
   - Secure resources.
5. **Implement**
   - Begin work on improvement goals;
   - Monitor and evaluate progress; and
   - Continuously improve, measure, obtain feedback.

Sample TQM Plan

The following is a sample plan outline used by a Federal agency to initiate its TQM program. It is intended only for reference, to give agencies a comparative viewpoint of what TQM plans can look like.

14-Step Sample Initial TQM Plan

Reprinted with permission of the Office of Quality Management of the U.S. Department of Defense from *Sample Initial TQM Plan* (Washington, DC: 1991).

Step 1 Executive Commitment to Total Quality Management

Train/orient top executive team in such Quality principles as the principles of TQM, the application of TQM within the organization, a team approach to Quality Improvement, and the importance of top management commitment.

Step 2 Create a Vision and Philosophy

- Formulate a vision and philosophy that will guide the organization's quality efforts.
- Issue a policy statement on the organization's principles of quality.

Step 3 Establish a Quality Council*

- Include top executives from the headquarters office and the field.
- Include the head of the agency on the Council or charter the Council to act on behalf of the head of the agency.

Step 4 Develop a Total Quality Management Strategy

- Determine an approach to institutionalizing quality in the organization.
- Determine the local leadership structure for TQM efforts, such as establishing local quality councils.
- Incorporate TQM activities into the strategic and business planning processes.
- Establish a system for organizational units to set quality improvement goals.
- Determine how and when to involve the employee union in implementation of TQM.
- Use existing management systems, wherever appropriate, in implementing TQM.

Step 5 Select Organization to Implement Total Quality Management

- Determine the readiness of the organization.
- Decide on the scope of implementation (across the organization or within a limited number of components).

Step 6 Conduct Training Needs Analysis

- Analyze training needs of executives, managers, and employees.
- Determine what types of courses need to be developed (awareness, problem solving, group dynamics, statistics, etc.) for each group.

Step 7 Determine Resources for Implementation

- Determine time frames and costs for developing and conducting training.

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* **Note:** Quality Councils are no longer in vogue in organizations starting TQM programs. Overall organization support and implementation responsibility has shifted to management teams that have the institutional authority to make decisions affecting coordination and policy.

- Identify the source of funding for training and award systems.
- Determine where in-house staff can develop and conduct training.

Step 8 Select Suppliers of Training and Expertise

- Identify individuals with quality expertise to serve as consultants.
- Identify suppliers of training.
- Develop and conduct training.

Step 9 Identify Standards and Measures

- Ensure that organizational units develop standards for measuring whether products and services meet customer requirements.
- Adjust existing measurement and management systems to measure whether customer requirements are being met.

Step 10 Institutionalize Total Quality Management

- Institutionalize systems for training, involving, rewarding, and recognizing employees.
- Institutionalize strategies, goal-setting, and measurement of improvements in quality.
- Institutionalize process analysis and structure problem-solving approaches.

Step 11 Monitor and Evaluate Results

- Monitor the progress of teams on quality improvement projects.
- Track quality improvements against goals.

Step 12 Publicize and Recognize

- Publicize successes.
- Reward and recognize quality improvement.
- Promote TQM throughout the organization.

Step 13 Adjust the Total Quality Management Process

- Use feedback to modify and improve the process.
- Expand to other segments of the organization.

Step 14 Management Improvement

- Select new processes to improve.
- Continue to improve all processes to remove defects.

Notes

1. W. R. Cozens. "Key elements of agency survival." *Residential Treatment for Children and Youth, 14* (1997), pp. 53-52.
2. L. Yount. *Total quality management: An overview* (Arlington, VA: Lynnette Yount Associates, 1994).
3. L. Yount. *Total quality management: Using the tools to get started* (Arlington, VA: Lynnette Yount Associates, 1994), p. 51. These steps were drawn from the Xerox Corporation's Benchmarking Model; no reference available.

APPENDIX A

Sample Strategic Planning Process

Adapted with permission of Resource Associates Corporation.

Key Elements of a Strategic Plan

This outline is designed to assist you in developing a format for the strategic planning process. This format has been successfully used by several CWLA agencies.

- Vision
- Mission
- Priorities
- Objectives with Measures
- Strategies
- Organizational Structure
- Resource Allocation(s)

Strategic Planning Process

Methodology

Voices—Customers, Employees, Stockholders

Input—Strengths, Weaknesses, Opportunities, Threats

Vision—What we want to become

Mission—What business we are in; what we do

Priorities—Based on the input from the three voices and corporate values

Objectives—What we want to achieve

Strategies—How we will achieve our objectives

Critical Business Processes—Major cross-functional work processes that are critical to your success

Process

1. **Vision Statement**

- What is the *Vision* of your organization? What will your organization look like in the future?
- The Vision Statement of an organization provides the focus for managers and employees alike. An understanding of this Vision provides the foundation for day-to-day decisions that must be made.

2. **External Assessment**

Market Segments and Opportunities

- What services do we offer?
- What customer needs do these services satisfy?
- Are there other ways of satisfying these needs?
- Are these needs growing? stable? declining?
- What market segments currently exist? (Describe these segments in terms of commonality, customer population, or needs.)
- What is the size of our "defined" market?
- What do our customers consider to be of value in the services offered? (If service is a key issue, be specific as to the nature of the service provided.)
- How are we perceived in these different segments?
- Awareness of our services?

- Risks associated with trying or evaluating our services?
- Our track record and reputations?

3. Competitive Analysis—(Our Company)

- Who are our competitors in each of these segments, and what advantage do they have?
- What are our strengths relative to competition?
- What distinguishes us from our competitors?
- What distinguishes our competition from us?

4. Trend Analysis

This section deals with an understanding of the larger economic, social, political, and cultural issues present in the marketplace. As we determine emerging trends, which can have either a positive or negative effect on our business, we will be better able to respond to them.

- What will the child welfare industry be like in three to five years?
- What will our customers be like in three to five years?
- What emerging trends in demographics, work force values, economic, political, environmental, or technical factors will effect our business short- and long-term?
- What potential opportunities and risks are inherent in these trends?
- Based on our understanding of the above, what specific issues need to be addressed?

5. Internal Appraisal

Structure and Function

- Is our organization effectively structured to respond to the needs of our customers?
- Is our organization effectively structured to respond to the needs of the employees?
- Is our organization easy to do business with?

- Are we as responsive to customer expectations in the following areas as we would like to be or is this an opportunity for improvement? If so, how can we improve:

—Intake & Referral Process?

—Assessment of Need?

—Delivery of Services?

—Aftercare Services?

—Conducting Outcome Evaluations?

—Working with Family Members?

—Dealing with Cultural Diversity?

- Where does the responsibility lie for revenue/expenses? Is this the most effective method for managing finances?
- Have clear customer expectation measurements been established and are they monitored?

Resources...Products

- Are our current services offered adequate to meet the needs of the market?
- Are there additional new service opportunities?

Support

- Do we have adequate resources in place to support our service and efforts?
- What additional resources are required?

Other

- What additional resources are needed in the following areas?

—Staff...

—Financial...

—Facilities...

—Equipment...

—Training...

—Evaluation...

6. **Strengths and Limitations**

   - Based on our understanding of the analysis conducted so far, what are our strengths and limitations?

7. **Resources...Organizational Teamwork**

   - Is there a high level of effective communications between the following groups?

   Administrator—Staff

   Professional Staff—Support Staff

   Direct Care—Supervisory

   Support Staff—Line Staff

   Senior Management—Middle Management

   Staff—Clients

   Staff—Family Members

   Board—Staff

   Executive Management—Staff

   - How effective is our organization in searching out change and capitalizing on it?
   - How effective is our organization in managing change?
   - Is there a risk-taking environment within your organization which is supported by management?

8. **Mission Statement**

   - The mission is a statement of what the organization will achieve in a specific period of time. It defines the boundaries of the business, the customer population, what must be accomplished, and how these accomplishments will be measured. It is a vision of what the organization and its people have the potential to become.
   - Truly effective organizations are ones where every individual within the organization knows what the mission is and what his or her role is in seeing that it is achieved.
   - Based on your analysis, what do you see as the mission for your organization?

APPENDIX B

Ten Unique Characteristics of High Performance Teams

Reprinted with permission of the Association for Quality and Participation from M. E. Collins, "High Performance Teams in the Workplace." In *The Spirit of Working Together: Proceedings of AQP's 17th Annual Spring Conference,* Cincinnati, Ohio, 1995.

1. Most high performance team members are physically distanced from each other.
2. Conflicts within the teams are viewed as differences of opinions.
3. The organizations of these high performance teams had *employee involvement in place* prior to *any quality initiatives.*
4. Membership represents traditionally underrepresented populations:
   a. More females than males (almost a 3 to 1 ratio);
   b. High school educated population (plus technical training);
   c. Baby Boom population (1946–1964); and/or
   d. Long-term employees (average is 9.5 years).
5. Interpersonal communications served as a validation of membership.
6. Recognition serves as a validation and motivation for high performance teams.
7. All teams experienced failure and thus failure served as a motivator.

8. These teams changed long standing organizational norms within the organization.
9. High performance team membership creates an opportunity for nontraditional entry into management.
10. High performance team members influence their family members and may make a difference in the next work generation.

APPENDIX C

Suggested Readings

Chapter One: TQM (General)

Crosby, P. B. (1985). *Quality without tears.* New York: The Penguin Group.

Juran, J. M. (1988). *Juran on planning for quality.* New York: Free Press.

Peters, T. J. (1988). *Thriving on chaos: Handbook for a management revolution.* New York: Harper & Row, Publishers.

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Chapter Two: Customer Service

Carlzon, J. (1987). *Moments of truth.* New York: Ballinger Publishing Co.

Davidow, W. H., & Uttal, B. (1990). *Total customer service.* New York: HarperPerennial.

Guaspari, J. (1988). *The customer connection.* New York: AMACOM.

Heskett, J. L., Sasser, Jr., W. Earl, & Hart, C. W. L. (1990). *Service breakthroughs.* New York: The Free Press.

Chapter Three: Leadership: The Role of Management in a TQM Organization

Bennis, W., & Nanus, B. (1985). *Leaders: The strategy for taking charge.* New York: Harper & Row Publishers.

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Chapter Four: Team Work and the Role of Employees

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Torres, C., & Spiegel, J. (1996). *Self-directed work teams: A primer.* San Francisco: Pfeiffer.

Chapter Five: Continous Quality Improvement and Measurement

Brennan, E. J. (1989). *Performance management workbook.* Englewood, NJ: Prentice Hall.

Deming, W. E. (1985). *Out of the crisis.* Cambridge, MA: MIT Center for Advanced Engineering Study.

Imai, M. (1986). *Kaizen: The key to Japanese competitive success.* New York: Random House.

Ishikawa, K. (1985). *What is total quality control? The Japanese way.* Englewood Cliffs, NJ: Prentice Hall, Inc.

Shaw, J. (1996). *Customer-inspired quality.* San Francisco: Pfeiffer.

Chapter Six: TQM Work Process Analysis

Brassard, M. (Ed.). (1988). *The memory jogger: A pocket guide of tools for continuous improvement.* Methuen, MA: GOAL/QPC.

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Stewart, D. W., & Shamdasani, P. N. (1995). *Focus groups: Theory and practice.* Thousand Oaks, CA: Sage Publishing, Inc..

Chapter Seven: How TQM Is Accomplished

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About the Authors

John Hodge-Williams, CEO and President of Woodbourne Center, Inc., brought TQM and its practices to Woodbourne in 1992. He has developed five- and two-day workshops for executives of CWLA member agencies and has spoken extensively throughout the United States and Great Britain on improving organizational performance. He has published articles and contributed extensively to this book.

Joy F. Spratley Wynn, Director of Special Projects at the Woodbourne Center, has developed a one-week training course on training team leaders and facilitation, entitled "Sparking Innovation Through Self-Directed Work Teams." She was an editor for the original manuscript.

Cheryl Mason Godsey, Director of Human Resources at Woodbourne, worked closely with Scott and helped to develop the materials on customer services.

Left to right: John Hodge-Williams, Cheryl Mason Godsey, and Joy Spratley Wynn

Quality-Centered/Team-Focused Management

With the nationwide implementation of managed care and the eroding financial base for children's services, agencies need new organizational systems to survive. This handbook provides an overview of one new system, Total Quality Management (TQM), as it relates to the child welfare field. The chapters cover such topics as customer service, leadership, team work, and quality improvement. In the last chapters of this useful guide, the authors present a TQM work process analysis, discuss how TQM is accomplished within an agency, and finally describe the specific steps in the TQM process.

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